Briarwood Animal Hospital

NEW PATIENT INFORMATION FORM

(Please Print)

OWNER INFORMATION

Owner's last name: First: Middle: E-Mail Address

Spouse's last name: First: Middle: E-Mail Address

Address: City: State: Zip Code:

Social Security no.: Driver's License no.: Home phone no.: ( )

Occupation: Employer: Employer phone no.: ( )

Chose clinic because/referred to clinic by:

☐ Personal Recommendation – Someone we may thank? Please list name:

PATIENT INFORMATION

Pet's Name: Breed: Color: Sex:

Spayed / Neutered? ☐ Yes ☐ No Birth date: Allergies or Reactions:

Dogs Owners – Please indicate below to the best of your knowledge the last date your dog has had the following

Cats Owners - Please indicate below to the best of your knowledge the last date your cat has had the following

Rabies Vaccine	Heartworm Test	Rabies Vaccine	Leukemia Vaccine
DHPP Combo Vaccine	Fecal Test	FVRCP Combo Vaccine	Leukemia Test
Bordetella		Fecal Test	Bordetella

It would be helpful to the treatment of your pet if we could obtain his / her previous medical records. May we contact your previous Veterinarian to obtain them? ☐ Yes ☐ No Veterinarian Name, City, State

Please include any additional information regarding your pet that you feel may be important to us.

Are any of the following a concern to you in your pet's behavior? Please check all that apply.

☐ Excessive Barking	☐ Shedding	☐ Excessive Itching / Scratching	☐ Wetting / Spraying
☐ Overly Rambunctious / Enthusiastic	☐ Housebreaking	☐ Straying away from home	☐ Problems w/ children
☐ Biting	☐ Odor	☐ Other	

Is your pet currently on a special diet or medication? ☐ Yes ☐ No If so, what:

Is your pet on Heartworm prevention? ☐ Revolution ☐ Heartguard ☐ Interceptor ☐ Other

What food does your pet eat?

Do you have any other pets? ☐ Yes ☐ No

Are they seen by this office? ☐ Yes ☐ No

(Please complete additional pet information form available on website)

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship: Home phone no.: ( )

Work phone no.: ( )

*** * PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED ****

We accept cash, checks, Visa, Mastercard - - - - -

I the undersigned authorize medical treatment of my pet by the doctors of Briarwood Animal Hospital and agree to pay all fees associated with that care regardless of estimated costs which are subject to change based on the needs of my pet and/or the care deemed necessary by this facility. In the event that I fail to make payment-in-full for all services rendered by the Briarwood Animal Hospital for the treatment of my pet, on all unpaid balances, in the event that my account becomes delinquent and is turned over for collections I agree to pay 33 1/3% collection and/or attorney fees, plus legal court costs. Accounts not paid in full within 30 days of treatment completion will have an interest and billing fee added to the unpaid balance each month.

Owner's signature *Date*