



**Blue Ravine Animal Hospital**  
**1770 Prairie City Road**  
**Folsom, CA 95630**  
**(916) 984-0990**

**Welcome** Thank you for giving us the opportunity to care for your pet. We will be happy to answer any questions you have about your pet's health. To insure the best care possible, please take the time to fill in this form completely. Thank you!

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First name \_\_\_\_\_ Last name \_\_\_\_\_ Middle Initial \_\_\_\_ Driver's License # \_\_\_\_\_  
Birthdate \_\_\_\_\_ **This information is for dispensing controlled substances only.**  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Mobile (\_\_\_\_) \_\_\_\_\_  
E-mail: \_\_\_\_\_ Spouse: \_\_\_\_\_  
Spouse Work Phone (\_\_\_\_) \_\_\_\_\_ Spouse Mobile (\_\_\_\_) \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
How did you learn of our hospital (please check all that apply?)  Recommendation, by whom? \_\_\_\_\_  
 Yellow pages  Sign  Internet  Other \_\_\_\_\_  
Are you (check any that apply)?  
 In Intel Employee  Over 65  A member of the Folsom Chamber of Commerce

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**Pet Health History**

Name of Pet #1 \_\_\_\_\_  Dog  Cat  Other \_\_\_\_\_  
Breed \_\_\_\_\_ Color \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Male  Neutered  Female  Spayed  
Vaccination History (Date and type of last vaccinations) \_\_\_\_\_  

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Pet's Current Medications \_\_\_\_\_ Describe your pet's diet \_\_\_\_\_  
Name of Pet #2 \_\_\_\_\_  Dog  Cat  Other \_\_\_\_\_  
Breed \_\_\_\_\_ Color \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Male  Neutered  Female  Spayed  
Vaccination History (Date and type of last vaccinations) \_\_\_\_\_  

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Pet's Current Medications \_\_\_\_\_ Describe your pet's diet \_\_\_\_\_

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**Authorization** I hereby authorize the veterinarian to examine, prescribe for, or treat the above described pet. I assume responsibility for all charges incurred in the care of this animal. I also understand that these charges will be paid at the time of release and that a deposit may be required for surgical treatment.

Check this box if you authorize your records to be released on an as needed basis. (i.e. Boarding, Grooming, Specialty Hospitals, Change in Veterinary Hospital, Etc.)

Signature of Owner/Authorized Agent \_\_\_\_\_ Date \_\_\_\_\_