

YOUR LIFE – YOUR HEALTH
OUR CONCERN



TREATMENT TO MINORS

Name of Patient: _____

Date Of Birth: _____

Many times parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some point in time be unable to accompany your child.

I hereby grant to: _____, permission to treat my child when they arrive to the office unaccompanied.

Signature of Parent: _____ Date: _____

Contact Phone Number: (1) _____ Cell ___ Work ___ Home ___

Contact Phone Number: (2) _____ Cell ___ Work ___ Home ___