Patient Account Number (minor) _____
Received Date _____
Scanned in Chart Date _____

Consent to Treat (Minor, Age 14-18)

Neatrour · Jain · Waschler · Levine · Lipton · Tang · Ritenour · Dunn · Bumgardner

I, _____, parent or legal guardian of _____, do hereby consent to any medical care determined by a physician to be necessary for the welfare of my child. Additionally, I accept financially responsibility upon check out on the date of service.

This authorization is effective from _____ to _____.

Signature of Parent or Legal Guardian

_____, _____

Witness Signature Witness Name (please print)

This consent form should be taken with the child to the physician's office when the child is taken in for examination or treatment

This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family address: _____

Telephone: Father: _____ home _____cell

Mother:_____ home _____cell

Child's Birthdate: _____

Allergies to drugs or foods: _____

Special medications: _____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy #: _____

Preferred Hospital: _____

Preferred Pharmacy: _____