Midwest Dermatology Clinic, PC
Consent to Treat Minors

Patient Name: _____ Account #: _____

Patient Date of Birth: _____

Parent or Legal Guardian: _____

Contact Information:

- Phone: _____
- Cell Phone: _____
- Work Phone: _____

Emergency Contact _____ Phone _____

This is to authorize and consent for the attending physician or his/her designee under supervision, to provide any necessary or routine medical or surgical treatment including examination, injection, blood draw and or diagnostic procedures including biopsy, pathology, laboratory and analysis.

This authorization will remain in effect unless so designated that such consent for treatment of a minor is canceled. I have completed and read all the information on this sheet. I certify this information is true and correct to the best of my knowledge. I will notify Midwest Dermatology Clinic of any change in this information.

Completed by: _____ Date: _____

Signature: _____