Dermatology Associates

OF THE LOWCOUNTRY

AUTHORIZATION TO TREAT A MINOR

This consent shall remain effective until ________________________, 200___. *(Please define the period as one day, one week, one month or a year – this form cannot exceed one year)*

I (We) the undersigned parent(s) or legal guardian of _________________________________, a minor, do hereby authorize and consent to medical treatment rendered under the general or special supervision of any member of the medical staff. It is understood that this authorization is given only after a specific diagnosis has been made and is granted to provide authority and power to render care, which the aforementioned provider in the exercise of his best judgment may deem advisable. A minor, by law, **must** be accompanied by a parent/guardian on the first scheduled appointment.

Please remember that co- payments and any additional fees incurred must be paid at time of service.

List any Restrictions:____

Address:_______________________________________ City:___________________ State:_______ Zip:______

Patient Date of Birth:____

Allergies:____

Medications:____

Health Problems:____

TELEPHONE NUMBERS WHERE PARENT(S)/GUARDIAN MAY BE REACHED

Mother:_______________________________ Home:_______________________ Work:____________________

Father:_________________________________ Home:_______________________ Work:____________________

Legal Guardian:________________________ Home:_______________________ Work:____________________

Primary Care Physician:____

Address:______________________________City:__________________State:________ Phone: ______________

INSURANCE PROVIDER **(Please bring your insurance card(s) & photo id)**

Primary

Insurance Company:____ Policy #____________________

Secondary (if applicable)

Insurance Company:____ Policy #____________________

____ ________________________

Signature of Parent/Legal Guardian **Date**

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