

## CONSENT TO TREAT MINOR WITHOUT A PARENT/GUARDIAN

**This consent applies to established patients only. New patients under 18 must have a parent or legal guardian present at time of initial visit**

Date: \_\_\_\_\_

Name of Minor: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name of Parent(s) or Guardian(s): \_\_\_\_\_

Person(s) Authorized To Bring Minor: \_\_\_\_\_

Relationship to Minor: \_\_\_\_\_

This authorization is in effect from: \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_  
*Signature of Parent or Guardian*

\_\_\_\_\_  
*Printed Name of Parent or Guardian*