

MOTHER _____ SS # _____

ADDRESS _____ DOB _____
Street/PO Box City State Zip Code

PHONE () - WORK PHONE () - EMPLOYER _____

FATHER _____ SS # _____

ADDRESS _____ DOB _____
Street/PO Box City State Zip Code

PHONE () - WORK PHONE () - EMPLOYER _____

PRIMARY INSURANCE:

INSURANCE NAME _____ GROUP # _____ ID# _____

POLICY HOLDER _____ DATE OF BIRTH _____ RELATIONSHIP _____

EMPLOYER _____ EFFECTIVE DATE _____ SS# _____

SECONDARY INSURANCE:

INSURANCE NAME _____ GROUP # _____ ID# _____

POLICY HOLDER _____ DATE OF BIRTH _____ RELATIONSHIP _____

EMPLOYER _____ EFFECTIVE DATE _____ SS# _____

EMERGENCY CONTACTS:

NAME _____ PHONE _____ RELATIONSHIP _____

NAME _____ PHONE _____ RELATIONSHIP _____

AUTHORIZATION TO TREAT A MINOR

--I (We) the undersigned parent, parents and/or legal guardian of _____ DOB _____,
_____ DOB _____, _____ DOB _____, _____ DOB _____ and
_____ DOB _____ minor(s), do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical
diagnosis rendered under the general or special supervision of any duly licensed physician licensed under the provisions of the laws of the state of Indiana. It is
understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and
power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be
made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot
be reached.

Signature: _____ **Date:** _____
Father, Mother, or Legal Guardian

The following people may present the above minor(s) for treatment:

Name: _____ Relationship: _____

THIS CONSENT SHALL REMAIN EFFECTIVE FOR ONE CALENDAR YEAR