1719 Main Street
Unionville, MO 63565
(660) 947-7325

PEDIATRIC PAPERWORK

Please fill out this form as completely and accurately as possible. All information requested below is necessary for us to serve your child with the best possible care.

About The Child

First Name: ____________________________ MI:____ Last Name:__________________________

Birth Date (MM/DD/YYYY):______________________ Age:________ Gender: ▫M ▫F

Height: ________________ Weight: ________________ SSN# _______-_____-___________

Address:____

City: ________________________________ State:____________ Zip:___________________

Physician/Pediatrician: _________________________________ Allergies: ___________________
Parent/Legal Guardian: _____________________________________ Phone:(___)____________
Email:____
Whom may we thank for referring you to our office? _____________________________________

Purpose Of Visit

Describe the purpose of today's visit:

____
____
____

Is the purpose of today's visit related to:
▫Sports ▫Auto ▫Fall ▫Home Injury ▫Chronic Discomfort ▫Other
Explain: ____

When did this condition begin? ____

Has this condition:
▫become worse ▫ stayed constant ▫comes and goes

Does this condition interfere with:
▫sleep ▫daily routine ▫other activities
Explain: ____
Has this condition ever happened before? ▫Yes ▫No
Have you seen other doctors for this condition? ▫Yes ▫No
Doctor's Name(s): ____
Type of Treatment: ____

Child's Health History
Please check each of the following the child has now or has had in the past. While they may seem unrelated to the purpose of the visit, they can affect the overall diagnosis and course of care.

▫Vision problems	▫Pink eye	▫Headaches	▫Hyperactivity
▫Constipation	▫Bed wetting	▫Frequent colds	▫Ear problems
▫Sleeping disorders	▫Irritability	▫Allergies	▫Tubes in ears
▫Colic	▫Asthma	▫Breathing problems	▫Digestive problems
▫Attention problems	▫Skin problems	▫Other___________________________________	

Is your child on any time-release, delayed-release, or extended-release medication? ▫Y▫N

Vaccinations
Please check which of the following statements best describes your child and vaccinations.
▫I have chosen not to vaccinate my child.
▫My child is partially vaccinated.
▫My child has received all vaccinations on the medical vaccine schedule.
Any noted effects or reactions?____

Child's Current Heath Status
Is your child accident prone? ▫Y ▫N ▫Unsure
Has your child ever:
...been hospitalized? ▫Y ▫N
...had a severe fall? ▫Y ▫N
...been in a car accident? ▫Y ▫N
Has your child ever taken antibiotics? ▫Y ▫N
If yes, explain for what condition(s) and for how long:
____
____
Does your child have trouble interacting with schoolmates or friends? ▫Y ▫N
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits a rocking behavior? ▫Y ▫N
What improvements (if any) in your child's health or behavior would you like to accomplish?
____
____

A. Maternal Health (Biological Mother)

1. ▫Y ▫N Is this your biological child? (If no, please answer numbers 2-12 for the biological mother if you have the information, otherwise skip to Section B.)
2. ▫Y ▫N History of miscarriages. If yes, how many? ____________
3. Number of "silver" dental fillings (amalgams) at time of pregnancy:_______
4. ▫Y ▫N Did you have any new silver fillings put in, or old ones repaired or removed during the pregnancy?
5. ▫Y ▫N Did you receive any vaccinations during the pregnancy?___________________
6. ▫Y ▫N Did you receive any flu shots during your pregnancy?
7. Mother's Rh status, if known (circle one): + or -

8. ▫Y ▫N Did you ever receive Rhogam shots? How many? ___________
9. ▫Y ▫N Mother's thyroid status: (Circle) Normal Hyperthyroid Hypothyroid (low)
10. ▫Y ▫N Diabetic? (Circle): Type-I Type-II Gestational Insipidus
11. Mother's occupation before and during pregnancy: _________________________________
12. During the pregnancy did you use any: (All answers are kept strictly confidential)
    - ▫Y ▫N Street Drugs. Please list: ____
    - ▫Y ▫N Alcohol
    - ▫Y ▫N Cigarettes. How many packs per day? ___________
    - ▫Y ▫N Prescription Drugs. Please list: ____
    - ▫Y ▫N Were you on SSRI's? (For depression or anxiety)

B. The Pregnancy

1. Any problems with the pregnancy? ▫Y ▫N If yes, please explain:
   ____
2. ▫Y ▫N Bacterial Infections
3. ▫Y ▫N Antibiotics
4. ▫Y ▫N Hospitalized during the pregnancy?
5. ▫Y ▫N Use of fertility drugs?
6. ▫Y ▫N In-vitro fertilization?

C. The Birth

1. ▫Vaginal ▫C-Section; Reason:_________________________ ▫VBAC
2. Approximately how long did labor last? ______________ hours
3. How long did you push? _____________ hours/minutes
4. ▫Y ▫N Were forceps or vacuum extraction used?
5. ▫Y ▫N Was labor induced?
6. ▫Y ▫N Medications used during labor: ____
7. ▫Y ▫N Medications used during delivery:_______________________________________
8. ▫Y ▫N Full term
9. ▫Y ▫N Premature; If yes, how many weeks early?_____________
10. ____/____ APGAR Scores (Or do you remember if they were good or poor? __________)
11. Baby's Birth weight: _________lbs ___________oz Length:_________________ inches
12. Complications:
    ____
13. ▫Y ▫N Was there any concern for birth trauma?
14. Medications given to baby at hospital: ____
15. ▫Y ▫N Did the any receive any antibiotics at the hospital?
16. ▫Y ▫N Did the baby receive the Hepatitis B vaccine while in the hospital?

Check any of the following if the child experienced it immediately after birth:
▫jaundice ▫feeding problems ▫respiratory problems ▫displaced or broken joints
▫other condition(s):____

D. Infancy/Toddler Years. (Birth to 2 years of age)

1. ▫Y ▫N Breastfed? How long? ______________________________
2. ▫Y ▫N Bottle-fed? Type of formula?:_______________________________________
3. ▫Y ▫N Difficulty latching on?
4. ▫Y ▫N Difficulty swallowing?
5. At what age were foods introduced?_________
6. ▫Y ▫N Excessive drooling?
7. ▫Y ▫N Poor head control-- "Floppy baby"? (Low muscle tone)
8. ▫Y ▫N Colic or Reflux
9. ▫Y ▫N Would "crash" when sick--> got dehydrated or even hospitalized.
10. ▫Y ▫N History of Thrush? (White overgrowth in mouth) How many times? _________
11. ▫Y ▫N History of strep? How many times? ____________ Antibiotics ▫Y ▫N
12. ▫Y ▫N Ear infections? How many times? _____________ Antibiotics ▫Y ▫N
13. ▫Y ▫N Seizures?
14. ▫Y ▫N Vaccine reactions? Describe: ____
15. ▫Y ▫N Asthma?
16. ▫Y ▫N Known allergies? List: ____
17. ▫Y ▫N Prone to diaper rash?
18. ▫Y ▫N Prone to body rashes? Location: ______________________________________
19. ▫Y ▫N Red ring around the anus/cracking/bleeding?
20. Describe sleep habits as an infant and as a toddler:
    ____
    ____
21. Texture of bowel movements: (Age 2 years and Younger).
    ▫Hard "rabbit pellets"
    ▫Enormous rock hard bowel movement
    ▫Formed, hard
    ▫Formed, soft (normal)
    ▫"Mashed potatoes"
    ▫Diarrhea
    ▫Diarrhea <u>and</u> Constipation
22. How often were the bowel movements as an infant? ___________________________
23. ▫Y ▫N Had to use laxatives or stool softeners
24. ▫Y ▫N Hospitalized for constipation at age 2 years or younger
25. ▫Y ▫N Bowel movements were very foul smelling
26. ▫Y ▫N Excessively gassy
27. ▫Y ▫N Gas was very foul smelling
28. ▫Y ▫N Caught a lot of colds as an infant
29. List any surgeries or procedures, age 2 or younger: _______________________________

30. CDC's Developmental Health Watch (by 12 months) Circle all that apply.
    - Does not crawl
    - Drags one side of the body while crawling (for over one month)
    - Cannot stand without support
    - Does not search for objects that are hidden while he or she watches
    - Says no single words ("mama" or "dada")
    - Does not learn to use gestures, such as waving or shaking head
    - Does not point to pictures or objects
    - Experiences a dramatic loss of skills he or she once had

31. CDC's Developmental Health Watch (by 24 months) Circle all that apply.
    - Does not walk by 18 months
    - Failed to develop a mature heel-toe walking pattern after several months of walking, or walked only on the toes
    - Did not speak at least 15 words
    - Did not use two-word sentences by age 2
    - By 15 months, did not seem to know the function of common household objects (brush, telephone, bell, fork, spoon, etc.)
    - Did not imitate actions or words by the end of this period
    - Did not follow simple instructions by age 2
    - Could not push a wheeled toy by age 2
    - Experienced a dramatic loss of skills he or she once had

32. Choose from the following three scenarios:
    ▫Your child hit milestones and spoke on time.
    ▫Your child hit milestones and spoke on time, then abruptly changed and was "lost".
    ▫Your child was never really right from birth, didn't hit milestones or speak on time.
    ▫Your child was developing normally and then hit a plateau (no abrupt change).
    ▫Other: ____

33. ▫Y ▫N If your child had speech and then lost it at some point.
    Age when speech was lost: ___________________________.
    Describe: ____
34. Please describe any illness, surgery, vaccines, antibiotics, etc. that occurred at the time of the speech loss:____
35. If vaccine related, what happened? ____
36. ▫Y ▫N Was your baby ever accidentally double vaccinated?
37. ▫Y ▫N Did you ever have to "catch up" on vaccinations?
38. ▫Y ▫N Good eye contact? (Circle one) Excellent Good Fair Poor None
39. ▫Y ▫N Known genetic disorders ____
40. ▫Y ▫N Known metabolic disorders ____

E. Older Childhood (2 years of age and up)

2. What is your child's primary form of communication? (Ex. Speaking, pointing, PECS, sign language,etc.)____
3. Please check all that apply:
   - ▫Y ▫N Does your child speak now?
   - ▫Y ▫N Does your child understand what is being said to them?
   - ▫Y ▫N Does he/she express needs and wants?
   - ▫Y ▫N Does he/she use "I want" statements?
   - ▫Y ▫N Will he/she go get items that you ask for?
   - ▫Y ▫N Does he/she answer by repeating your question?
   - ▫Y ▫N Does he/she initiate conversation?
4. Describe his/her speech: (Check all that apply).
   - ▫0 words, mumbles, makes some noises.
   - ▫1-2 words in a row.
   - ▫3-4 words in a row.
   - ▫1 sentence at a time.
   - ▫2-3 sentences in a row.
   - ▫Many sentences in a row.
   - ▫Language is highly developed, and appropriate.
   - ▫A "wall" of one-way conversation, always talking, doesn't need you to answer.
   - ▫Can sustain a back-and-forth conversation, not just reply to questions.
5. ▫Y ▫N Repeats stories he/she has heard on TV (scripting)
6. ▫Y ▫N Echoes or repeats what you say
7. ▫Y ▫N Repeats some words or phrases over and over all day
8. ▫Y ▫N Speaks in a mechanical voice
9. ▫Y ▫N Speaks in a singsong voice
10. ▫Y ▫N Has a sense of humor and easily understands jokes
11. ▫Y ▫N Has a sense of humor, but does not get jokes most of the time

Learning

1. How is your child doing in school? ____
2. ▫Y ▫N Has learning difficulties
3. ▫Y ▫N Fine motor skills are poor (difficulty writing letters, etc.)
4. ▫Y ▫N Performs work on his/her grade level?
5. ▫Y ▫N Has been held back a grade before.
6. ▫Y ▫N Is currently being homeschooled
7. ▫Y ▫N Has been homeschooled in the past
8. ▫Y ▫N Is your child in an Autism or Special Education class?
9. ▫Y ▫N Does your child hit, kick, bite, etc. other students or teachers?
10. How is your relationship with the school as a parent? ___________________________________

Sensory

1. ▫Y ▫N Any rocking, hand flapping, swinging, twirling?
2. ▫Y ▫N Sensitive to noise/sound; describe: ____
3. ▫Y ▫N Does not lie, the texture of finger paints, order of Playdoh, etc.
4. ▫Y ▫N Sensitive to textures of food
5. ▫Y ▫N Sensitive to hot or cold foods
6. ▫Y ▫N Does not like to have teeth brushed
7. ▫Y ▫N Sensitive to smells
8. ▫Y ▫N Sensitive to light
9. ▫Y ▫N Bothered by seams and tags on clothing
10. ▫Y ▫N Likes to be hugged or touched
11. ▫Y ▫N Pressure is calming
12. ▫Y ▫N Sensory seeker (Loves to swing, twirl, jump, textures no problem)
13. ▫Y ▫N Sensory avoider (avoids the playground equipment, textures are a problem)
14. ▫Y ▫N Gets overwhelmed by crowds, Wal-Mart, parties, etc.
15. ▫Y ▫N High pain tolerance; describe:____

Vision Therapy Screening Section:

1. ▫Y ▫N Good eye contact (Circle one): Excellent Good Fair Poor None
2. ▫Y ▫N Finger stimming/flapping right in front of eyes
3. ▫Y ▫N Does he/she do any sideways glancing?
4. ▫Y ▫N Hold toys up very close to eyes, or just above or to the side of eyes
5. ▫Y ▫N Head frequently tilted to one side
6. ▫Y ▫N History of Lazy Eye; Which eye? R▫ L▫
7. ▫Y ▫N Has had the lazy eye corrected with surgery
8. ▫Y ▫N Are eyes crossed? (Strabismus)
9. ▫Y ▫N Has dyslexia
10. ▫Y ▫N Other visual impairments; List: ____
11. ▫Y ▫N Avoids homework, has been called "lazy"?
12. ▫Y ▫N Is very intelligent, but makes poor grades in school
13. ▫Y ▫N Skips over lines when reading
14. ▫Y ▫N Dislikes or avoids reading
15. ▫Y ▫N Dislikes movies in 3-D
16. ▫Y ▫N Is careful on the stairs, holds the rail, one foot at a time, sits down to do stairs, etc.
17. ▫Y ▫N Catches a ball easily and accurately
18. ▫Y ▫N Sometimes trips or stumbles over nothing; tends to be clumsy
19. ▫Y ▫N Sometimes bumps into the door frame when going through a doorway
20. ▫Y ▫N Has had prism lenses or Vision Therapy? When?:____________________________

GI and Immune:

1. ▫Y ▫N Skin is very pale
2. ▫Y ▫N Dark under-eye circles (circle one): Mild Moderate Dark Very dark
3. ▫Y ▫N Puffiness under lower lashes
4. ▫Y ▫N Frequent runny nose / Seasonal allergies
5. ▫Y ▫N Frequent, brief grabbing at penis or vaginal area, as if felt sharp pain
6. ▫Y ▫N Cheeks and ears sometimes flush bright red for no reason (Not when exercising or has a fever, just at odd random times)
7. ▫Y ▫N Eats inedible things (pica)
8. ▫Y ▫N Known or suspected allergies or sensitivities
9. ▫Y ▫N Celiac disease (Gluten allergy)
10. ▫Y ▫N Never gets sick
11. ▫Y ▫N Catches every cold "coming and going"
12. ▫Y ▫N Sinus infections. How many?_________________ Antibiotics? Y▫N▫
13. ▫Y ▫N Ear infections over the age of 2? How many? _______________
14. ▫Y ▫N Do any smokers live in the home?
15. ▫Y ▫N Does your child seem less autistic when they have a fever?
16. ▫Y ▫N Strep Infections. How many? ______________ Antibiotics Y▫N▫
17. ▫Y ▫N Currently has some warts
18. ▫Y ▫N Molluscum Contagiosum
19. ▫Y ▫N Cold sores (fever blisters)
20. ▫Y ▫N Asthma
21. ▫Y ▫N Eczema
22. ▫Y ▫N Rashes; describe: ____
23. ▫Y ▫N Hives; location(s):____
24. ▫Y ▫N Dermatographism (writing/scratching on the skin causes a localized hive reaction)
25. ▫Y ▫N Ringworm

Goals For My Child's Care

Children are seen by chiropractors for a variety of reasons. Some go for relief of pain, some correct the cause of the pain, and others for corrections of malfunctions in their bodies. Please check the type of care desired so that we may be guided by your wishes whenever possible.

▫RELIEF CARE--- symptomatic replied of pain or discomfort

▫CORRECTIVE CARE--- correcting and relieving the cause of the problem as well as the symptoms

▫COMPREHENSIVE CARE--- bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care.

▫I wish the doctor to select the type of care appropriate for my child.

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each of the statements and initial your agreement to the following:

Initials _____ I instruct the doctor to deliver care that, in her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ In the event that may warrant the need to take radiographs, I realize that an x-ray examination may be hazardous to an unborn child and I certify to the best of my knowledge I am not pregnant. If I am or do become pregnant I will notify the doctor immediately.
Date of last menstrual period._____________________

Initials _____ I grant the permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, e-mails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print the child's full name: ____

Signature Date (MM/DD/YYYY)

FINANCIAL POLICY

At Heartland Chiropractic & Wellness, we understand that the cost of healthcare is a key concern for our patients. Although patient care is our main priority, we hope that you will assist us by understanding your responsibility as it relates to our Financial Policy. If you have any questions regarding our policy, a member of our staff will be glad to assist you.

Health Insurance

As a courtesy to you, when given a copy of your insurance card, we will call and verify your benefits for chiropractic care in our office.

We do Not file claims for acupuncture, massage, lab work, orthotics, supplements or merchandise to your insurance.

If you receive care that we do not file for, you will need to pay for the services rendered. If you would like to submit the charges yourself for reimbursement, we will be happy to make a copy of your fee slip. Please remember- the benefits information your insurance company quotes us is not a guarantee of payment from them and any remaining fees are due immediately from you.

Medicare

Medicare covers spinal adjustments only. After your yearly deductible has been met, Medicare should cover 80% of the allowed costs for adjustments. You will be responsible for the remaining 20%, as well as the cost for any non-covered services.

You will be asked to fill out and sign an Advanced Beneficiary Notice (ABN) for non-covered services.

Secondary Insurance

Please inform us of any secondary insurance you may have. We will be glad to file chiropractic claims to your secondary insurance after your primary insurance has processed the claim(s).

Auto Accidents

If you've not already done so, please notify your auto insurance carrier of your accident immediately. We will have fill out the proper document so we can file claims with your insurance carrier. We will call your adjuster to gather the information we need to file.

If you reach the maximum amount payable under your auto insurance, we will file the claim through your health insurance. Although you are ultimately responsible for your Bill, we will do whatever we can to secure reimbursement from your insurance carrier. Once the claim is settled or if you spend/terminate care against physician's recommendations, any remaining fees are due from you.

If there is a third party involved (such as an attorney), you'll be asked to make partial payments as care is received. Accepting assignment and/or liens is done so under a pre-qualified understanding between the patient, this office and the third party payor(s). Establishing an honest ethical working relationship allows this office to continue accepting liens and assisting patients in their goals for better health. Any and all changes of the original party's agreement, independent of this office's now ledge or consideration, immediately disqualifies the terms of that agreement and demands immediate payment on the outstanding balance.

Patients Without Insurance

We request that 100% of all visits be paid in full at the time of service.

We gladly accept cash, checks, credit/debit cards, HSA, and flex-pay cards.

Changes to any appointment should be made 24 hours in advance to avoid a $25 service fee. Reschedules should be confirmed and done directly with the front desk. The Doctor is the only one qualified to change your treatment schedule.

When you pay by check you expressly authorize this office, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check, plus a processing fee of $25 and any acceptable sales tax. The use of a check for payment is your acknowledgment and acceptance of this policy and its terms.

Financial arrangements are valid under your present condition. They are subject to renewal by the start of each New Year. Should changes arise in your medical or financial situation that would affect your current financial agreement, you must notify this office prior to your care. Should you discontinue care or be released from further service, at this office, all outstanding balances are due upon notification.

Any past due balance not paid within 90 days will be reported to the credit bureau and turned over to an attorney, small claims court, or agency for collections. You will be responsible for all changes related to this collection process. Please keep your account current to avoid any action or blemish on your credit history.

Thank you for your understanding of our financial policy. Please let us know if you have any questions.

I have read, understand and agree to this Financial Policy in its entirety.

____

Printed Name

____ ____________________

Signature Date

PATIENT PRIVACY

This practice is committed to maintaining the privacy of your Protected Health Information (PHI), which includes information about your health condition and the care you receive from the practice. This notice details how this information may be used in the office. With consent from you, it is the policy of this office to use your PHI in the following manners:

Treatment: your PHI will be given to these professionals that require it to provide care.
Appointment reminders: our staff may call from time to time to remind you of appointments
Sign-in log: We maintain a log of incoming patients for our own statistical use
Medical doctors: it is the policy of this office to share our findings with your regular medical doctor. This helps us build a better understanding of how we may work together to improve your health.

In special circumstances, your PHI may be disclosed as in the following:

Personal representative: in accordance with applicable law that may represent you
Emergency situations
Abuse, neglect, and domestic violence
Law enforcement issues
Worker's Compensation claims
Avert a health threat

Your rights regarding your health information:

Right to inspect and copy your records: A written request must be submitted and cost of copying may be applied to such a request.
Amend your PHI by submitting a written request with an explicit reason.
Request restrictions on your PHI. However, this practice is not obligated to agree to any such restrictions.
Revoke consent at any time
Complain to the practice

Printed Name: ____

Signature: ____ Date: ________________________

CONSENT TO TREAT

The primary treatment used by the doctor of chiropractic is the spinal adjustment.
We will use that procedure to treat you.

The nature of the chiropractic adjustment.
We will use hands or a mechanical device upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. This audible is formally known as a "cavitation", which is simply a gas release from your joints. You may feel or sense movement in the joint(s) adjusted.

The material risks inherent in chiropractic adjustment.
As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations and muscle strain, and costovertebral strain and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious, but rare complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority, saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare".

The availability and nature of other treatment options.
Other treatment options for your condition include:
Self-administered, over-the-counter analgesics and rest
Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
Surgery
Note: There are risks and side effects that occur with these other treatment options.

The risks and dangers attendant to remaining untreated.
Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

Do Not Sign Until You Have Read and Understand the Above.

Please Check the Appropriate Block and Sign Below:

I have read ▫ or have had read to me ▫ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my Doctor of Chiropractic and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Date:_____________________________

____
Printed Name

____
Signature

____
Signature of Parent or Guardian (if a minor)

____
Authorized Doctor Signature