

MINOR CONSENT FORM

Patient Name: _____

Minor Age: _____ Date of Birth _____

Date of Initial Visit: _____

I give my consent for Dr. Helene M. Koch to consult, evaluate, and treat the above patient who is a minor at the date of initial visit. I also consent for future visits until the patient reaches the age of 18 and is no longer a minor.

Print Name of Guardian: _____

Signature of Guardian: _____ Date: _____

Relationship of Guardian: _____

Phone Number of Guardian: _____

Date patient will turn 18 years old: _____