MINOR PATIENT REGISTRATION & CONSENT TO TREAT

GILLIE
AESTHETICS | DERMATOLOGY

PATIENT INFORMATION

NAME : _____ DATE OF BIRTH : _____ AGE : _____

PARENT, GUARDIAN, OR RESPONSIBLE PARTY

Name :_____ Date of Birth : _____

Relationship to Patient : _____

Please list an emergency contact person (relative or friend not living with you):

Name : _____

Relationship : _____

Phone : _____

CONSENT TO TREATMENT

GILLIE Aesthetics and Dermatology treats pediatric patients of all ages, from infants to adolescents. Minor patients less than eighteen (18) years of age require parental consent for evaluation and treatment of skin disorders. Therefore, in-office procedures including physical examination, skin biopsies, injections, blood draws, and liquid nitrogen cryosurgery require parental consent. As the parent, guardian, or responsible party for the minor listed above. With this signature, I give consent for GILLIE Aesthetics and Dermatology to initiate evaluation and treatment during clinic visits deemed necessary by provider and staff. This consent if foregoing until I submit to revoke unless indicated by and "end date" written below.

SIGNATURE : _____ DATE : _____

CONSENT TO HAVE A NON-PARENT ADULT ACCOMPANY A MINOR

In the event I, the parent or guardian of the minor listed above, cannot personally attend a clinic visit to GILLIE Aesthetics and Dermatology, I authorize the following individual(s) to attend clinic visits and provide consent for treatment on my behalf:

_____

Relationship to above named minor : _____

I also give consent for the staff of GILLIE Aesthetics and Dermatology to provide emergency treatment in the unlikely event of an emergency.

SIGNATURE : _____ DATE : _____

PRINTED NAME : _____