MOELLER
DERMATOLOGY

Consent to Treatment of Minor Patient When Parents/Guardians are Temporarily Unavailable

The undersigned parent or guardian gives permission to Moeller Dermatology to treat and diagnose their minor child, including but not limited to, emergency, anesthetic, prescription, pathology or laboratory services when I am not available in person. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to provide authority to the provider of care to diagnose and treat the minor in the parent's/guardian's absence. This consent is only valid for the following date: _________________.
(Date of Appointment)

__________________________ Patient Name

__________________________ Patient Date of Birth
(Child must be 16 or older)

Current medical concerns:____
____

Current Medications:____
____

Known allergies:____

Insurance Company: ____

Insurance ID: ____

Subscriber: ______________________________ Subscriber Date of Birth: _____________

Insurance co-pays are due at the time of service. Please prepare your child to make the payment during check in.

________________________________ Parent/Guardian Name (please print)

________________________________ Phone

________________________________ Parent/Guardian Signature

________________________________ Date

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