Health Partnership
CLINIC

Consent for Treatment
Guardianship of Child or Incapacitated Adult

Patient Name (Last, First) _____

Date of Birth _____

Street Address _____

City/State/Zip _____

In case of emergency, who should we contact? _____

Relationship to patient _____

Phone Numbers: (1) _____ **(2)** _____

By signing below, I hereby state that I am the primary legal custodian or joint legal custodian of _____ being presented for treatment, and I agree to provide documentation of this relationship to Health Partnership Clinic.

By signing below, I am giving my consent as guardian of _____ for any of the following routine procedures deemed necessary by the professional staff of Health Partnership Clinic: examinations, x-rays, dental/medical treatment, immunizations. I understand there are no guarantees, either written or implied, on the outcome of any dental/medical exam or procedure. All attempts will be made to contact me if the doctor/dentist deems that procedures are necessary. I understand all of the preceding statements and will adhere to the stated policies.

_____

Name **Relationship to Child/Adult**

_____ _____

Signature of Patient or Legal Guardian **Date** **Signature of Witness** **Date**

Was consent obtained over the phone? ☐YES ☐NO

If yes, signature of person obtaining the consent_____ Date_____