FAMILY FIRST CHIROPRACTIC

4121 Washington Road, 2nd Floor, McMurray, PA 15317
(724) 941-9507 info@familyfirstchiro.net

Save this form to your desktop and email to info@familyfirstchiro.net

Consent to treatment of a minor

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize Family First Chiropractic to administer treatment as it so deems necessary to the minor. In the event that the minor has received treatment at your practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at Family First Chiropractic which are customarily completed and signed by patients at your practice as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form.

General Information

MINOR'S NAME

NAME OF CUSTODIAL PARENT/LEGAL GUARDIAN

RELATIONSHIP TO MINOR

☐ Custodial Parent ☐ Adoptive parent with custody ☐ Guardian by law*

☐ Other

*IF GUARDIAN BY LAW, DATE GUARDIANSHIP COMMENCED:

Guardian Information

ADDRESS, CITY, STATE, ZIP

SOCIAL SECURITY # BIRTH DATE

EMAIL HOME PHONE WORK PHONE

SIGNATURE (MUST BE SIGNED IN OFFICE) DATE

WITNESS' NAME WITNESS' SIGNATURE (MUST BE SIGNED IN OFFICE)