Minor Medical Consent Form

Be Well Women's Health

Patient Information

Name *

Middle Name

Age *

Date of Birth *

Month Day Year

Gender

Phone Number *

Area Code Phone Number

Email

example@example.com

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Insurance Information

Health Insurance Name

Insurance Policy ID

Name of Policy Holder *

Policy Holder's Date Of Birth *

Month Day Year

Policy Holder's Employer

Parent/Guardian or Emergency Contact Details

Name of Contact Person *

Relationship to the Patient *

If "Other" selected above, please explain briefly below

Primary Phone Number *

Area Code Phone Number

Secondary Phone Number

Area Code Phone Number

Medical Data

Please list any medical conditions and surgical procedures below.

Please list any medications and the reasons why are you taking them.

Please list anything you are allergic to and what reaction exposure may cause below.

Ex. Bees (Anyphylaxis), Penicillin (Rash) etc.

Please list any vaccines you have received (ex. HPV vaccine)

Acknowledgment And Authorization To Treat Minor

Minor / Dependent Name *

First Name Last Name

Minor / Dependent Date of Birth *

Month Day Year

*

- [ ] I certify that I am the legal guardian of the minor named above.
- [ ] I authorize Be Well Women's Health to evaluate and provide testing and treatment to my minor dependent.
- [ ] I hereby give consent for Be Well Women's Health to provide medical care to my minor child even when not accompanied by parent / legal guardian or when parent / legal guardian cannot be reached.
- [ ] I submit that I will be responsible for all charges for the care and treatment rendered.

Parent / Legal Guardian Name *

First Name Last Name

Parent / Legal Guardian Signature

Date Signed *

Month Day Year