UPSTATE DERMATOLOGY, PC

MINOR CONSENT FORM

Minor's Name: _____ Sex: M ___ F ___
First Middle Last

Date of Birth: ___/___/___ Social Security Number: _____
Month Day Year

Home Address: _____
Street Address

_____
City State ZIP

Parent/Legal Guardian: _____ Sex: M ___ F ___
First Middle Last

Date of Birth: ___/___/___ Social Security Number: _____
Month Day Year

Home Address: _____
Street Address

_____
City, State ZIP

Home Phone: _____ Work/Other Phone: _____

I give the Medical staff at Upstate Dermatology permission to treat

_____ for _____ for a period of _____.
Minor Diagnosis # of months

I take full financial responsibility for treatment of the minor listed above.

_____ _____
Parent/Legal Guardian (please sign) Date