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CONSENT FOR TREATMENT

Patient Name:_____ Date of Birth:_____

Phone Number:_____

Street Address:_____

City:_____ State:_____

Email:_____

Primary Care Physician Information

Physician Name:_____

Physician Number:_____

Physician Address:_____

City:_____ State:_____

ZIP:_____

Physician Fax:_____

EMERGENCY CONTACT

Full Name:_____ Relationship to patient:_____

Phone Number:_____

_____ _____
Client Signature Date

_____ _____
Parent Signature (if client is a minor) Date