PACIFIC GROVE
FAMILY MEDICINE

CONSENT TO TREAT A MINOR

Date: ______________________

I, ______________________ (parent/guardian), give permission to the doctors and/or medical staff at Pacific Grove Family Medicine to treat my child, ______________________ (patient), while I am not present.

This permission is effective ______________________ (date) until ______________________ (date).

If a co-payment is due at the time of the appointment, and I did not send my child with a form of payment please use the following credit card:

VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Card Holder Name: ______________________

Card Number: ______________________

Expiration Date: ______________________

CV2 Code: ______________________

Billing Zip Code: ______________________

Patient's Name: ______________________

Date of Birth: ______________________

Signed: ______________________

Printed Name: ______________________ Relation to Minor: ______________________

621 Forest Avenue, Pacific Grove, CA 93950