*Dan R. Baker, MD*

*1 Chisholm Trail, Suite 4100*

*Round Rock, TX 78681*

*Phone: 512/310-0900 Fax: 512/310-0318*

PARENTAL CONSENT FORM (OPTIONAL)

(PATIENTS UNDER 18 YEARS OLD)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize my son/daughter to be treated by Dan R. Baker, M.D. to provide my child with reasonable and proper medical care according to today’s standards without my presence. This authorizes my son/daughter to be seen:

\*\*\* ( ) today’s date of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

\*\*\* ( ) any future dates for medical appointments, physicals, treatments

\*\*\*This does not apply to immunizations as the forms MUST be signed by parent at the time\*\*\*\*

I do understand that it is my responsibility to schedule these appointments, and that I am financially obligated for these visits. I also understand that the staff is not responsible for any transportation issues or anything outside the consultation.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\**Please be sure to specify your authorization for a specific visit or for any future visits. \*\*\**