*Dan R. Baker, MD*

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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. \*\*\**