FIRSTEYECARE
Vision Made Clear

CONSENT TO TREAT MINOR PATIENT WITHOUT PARENT PRESENT

Patient's Full Name: _____ Date of Birth: _____

First Eye Care must receive permission from a child's parent or legal guardian before providing treatment in non-urgent situations. This form gives us legal permission to treat your child in the event that you cannot accompany them to the clinic for treatment. If the party accompanying your child (baby-sitter, friend, relative, ect.) does not present this information treatment may be denied.

Please send the insurance card and copay (if applicable) to the appointment.

Name of Health/Vision Ins. Carrier: _____

Primary's Name & DOB: _____

Identification Number: _____

Group Number: _____

Child's Health Information

Allergies: _____

Medications: _____

Other Important Medical Info: _____

_____

I grant _____ (an adult into whose case the minor has been entrusted) to arrange for and authorize routine & emergency treatment at First Eye care on (date)_____. This adult will be responsible for communicating all treatment discussions/ decisions to the parent/guardian. First Eye Care and its providers will not hold a separate phone discussion with the parent/guardian after the visit.

Signature: _____ Date: _____

I wish to give consent for the minor to receive medical care without an accompanying adult. This consent only applies to minor's age 16+.

Signature: _____ Date: _____