

Bee Caves Dermatology
5300 Bee Caves Rd., Bldg III, Suite 120 Austin, Texas 78746
Phone 512-329-6090 Fax 512-329-0125

Consent For Minor Patient to be Treated

Bee Caves Dermatology requires that a minor patient must be seen and accompanied by a parent or adult legal guardian at the first visit. After the initial visit, if the guardian or parent would like the minor patient to be seen unaccompanied, we must have signature authorization. Please fill out the form and fax, mail or deliver to the office.

Minor Patient Name _____

Patient Date of Birth and Age _____

Person giving consent for treatment

Name _____

Day Time Phone _____

Address _____

Relation: check one

_____ Parent

_____ Legal Guardian

_____ Managing Conservator of the Minor

Authorization (please mark appropriate space)

_____ I hereby give my consent to have _____ seen and treated by Bee Caves Dermatology, Mary Ann Martinez, M.D. without my presence

_____ I give authority to (check below) to consent to medical treatment for the above named patient in my absence

_____ educational institution in which the patient is enrolled

_____ adult who has care / control of the patient, please specify name and relation _____

_____ Date _____
Signature of Parent or Legal Guaradian