Restorative Health Clinic

6464 SW Borland Rd. Suite B-2
Tualatin, OR 97062
Telephone: 503-747-2021
Fax: 503-747-2802
www.restorativehealthclinic.com

Consent and Assessment for Minor/Ward

I acknowledge as parent/guardian of said patient that I understand all the information presented on this form pertains to said minor/ward.

Consent for evaluation and treatment is hereby given under the terms described in this document. It is agreed that I may discontinue the evaluation and treatment of said minor/ward at any time and that I am free to accept or reject the treatment provided for said minor/ward.

Signature of Parent/Guardian _____Date _____

Parent/Guardian Name (please print) _____

Patient Name (please print) _____

Emergency Consent for Minor/Ward

In the event that the undersigned parent/guardian of _____cannot be contacted through reasonable efforts, they hereby empower and grant to Dr. Vosloo/Dr. Day/Dr Coffin permission to consent and authorize medical and/or hospital care and treatment for my above child/ward.

I do herby indemnify and hold harmless the physicians, therapists, clinic and staff of Restorative Health Clinic who act in reliance upon this authorization.

Full name of Minor/Ward _____Relationship

Date of Birth_____Social Security Number_____

Signature of Parent/Guardian _____

Date _____

Are there any other legal/guardians authorized to make decisions on behalf of said minor/ward?

If Yes: Name _____ Phone # _____

If No: Sign here: _____