Stones River Dermatology, PLC
Minor Patient Registration and Consent to Treatment

PATIENT INFORMATION

Name _____

Date of Birth _____ Age _____

PARENT, GUARDIAN, OR RESPONSIBLE PARTY

Name _____

Relationship to Patient _____

Please list an emergency contact person (relative or friend not living with you):

Name _____

Relationship _____

Phone _____

CONSENT TO TREATMENT

Stones River Dermatology treats pediatric patients of all ages, from infants to adolescents. Minor patients less than eighteen (18) years of age require parental consent for evaluation and treatment of skin disorders. Therefore, in-office procedures including physical examination, skin biopsies, injections, blood draws, and liquid nitrogen cryosurgery require parental consent.

As the parent, guardian, or responsible party for the minor listed above, I give consent for Dr. Nelson and his staff to initiate evaluation and treatment during clinic visits. I understand and expect Dr. Nelson and his staff will communicate with me prior to invasive procedures involving local anesthesia, biopsy of the skin, or surgical excision, unless an unlikely emergency situation dictates otherwise.

Signature _____ **Date** _____

CONSENT TO HAVE A NON-PARENT ADULT ACCOMPANY A MINOR

In the event I, the parent or guardian of the minor listed above, cannot personally attend a clinic visit to Stones River Dermatology, I authorize the following individual(s) to attend clinic visits _____
Relationship to above named minor _____
Dr. Nelson and his staff will still notify me if invasive procedures involving local anesthesia, biopsy of the skin, or surgical excision are required during the clinic visit. I also give consent for Dr. Nelson and his staff to provide emergency treatment in the unlikely event of a life-threatening emergency.

Signature _____ **Date** _____