Puyallup Dermatology Clinic

Mark A. Crowe, M.D.
Jeffrey S. Newman, M.D., PhD
T. Keith Vaughan, M.D.

CONSENT FOR EVALUATION AND TREATMENT OF A MINOR

I, the undersigned parent or guardian of _____(Name of Child), a minor, (Date of birth _____) hereby give my permission for Dr. Mark Crowe, Dr. Jeffrey S. Newman, Dr. T. Keith Vaughan, or Dr. Dan Wiklund to evaluate and treat my child. This includes authority to perform minor diagnostic procedures and treatment. Unless otherwise stated below, this consent also includes the use of local anesthetic for the purpose of obtaining superficial skin specimens for evaluation or removal. This consent shall be effective from the date it is executed until the date I terminate it in writing. I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period. I understand payment is required at the time of service unless prior arrangements have been made. I understand that, if possible, I should attend all doctor appointments with my minor child. In my absence my signature on this form provides written, signed consent for evaluation and treatment.

I have read this form and certify that I understand its contents.

List any restrictions: _____

Allergies to Drugs or Foods: _____

Special Medications or Pertinent Information: _____

_____

Signature of Parent or Legal Guardian: _____Date:_____

Telephone Where Parents or Legal Guardian May Be Reached

Father: Home:_____ Cell:_____ Work:_____

Mother: Home:_____ Cell:_____ Work:_____

Legal Guardian: Home:_____ Cell:_____ Work:_____

Patients must bring or have on file with us a completed and signed Patient Registration form.

Insurance cards must be presented at each appointment.

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