Precision Health Group
3452 McKelvey Road
Bridgeton, Missouri 63044
314.739.8841

CONSENT TO TREAT A MINOR CHILD

PARENT/ GUARDIAN INFORMATION

☐ Check if Guarantor *(person responsible for charges not covered by insurance)*

I hereby authorize Dr. Matthew Lytle or Dr. Bryan Rasch and whomever he may designate as his assistants to administer treatment as he so deems necessary to (child's name) _____.

MOTHER'S NAME: _____ BIRTHDATE: _____

Address: _____
STREET CITY STATE ZIP

SOCIAL SECURITY NUMBER: _____ HOME PHONE: _____

Place of Employment: _____ WORK PHONE: _____

May we call you at work? ☐ Yes ☐ No

FATHER'S NAME: _____ BIRTHDATE: _____

Address: _____
STREET CITY STATE ZIP

SOCIAL SECURITY NUMBER: _____ HOME PHONE: _____

Place of Employment: _____ WORK PHONE: _____

May we call you at work? ☐ Yes ☐ No

Guarantor signature: _____ Date: _____

Email: _____

PEDIATRICIAN INFORMATION

Pediatrician Name: _____ Phone: _____

Address: _____
STREET CITY STATE ZIP

Reason for today's visit: _____