Pediatric Offices at Willow Bend
6529 W. Plano Pkwy Suite B
Plano Texas 75093

IF PATIENT IS UNDER THE AGE OF 18, PLEASE COMPLETE:

Name of Parent/Guardian:____

Phone Number(DAY)____

Employer____

If I am unable to accompany my above named **MINOR** child to an appointment, I hereby grant permission to the providers at Pediatric Offices at Willow Bend to examine and treat my child when he/she arrives at the office unaccompanied or is accompanied by someone other than a parent or guardian.

____

Signature of Parent/Guardian Date

Please provide names of all persons allowed to seek medical treatment and information regarding your child.

____

Name Relation

____

Name Relation

____

Name Relation

____

Name Relation

____

Signature of Parent/Guardian Date