Davis Family Chiropractic

1484 OH-46N Ste. 7
Jefferson, OH 44047
Phone: (440) 624-4214
Fax: (440) 624-4299

Consent Form to Treat a Minor

Patient Name: _____

I hereby request and authorize Dr. Adam Davis to perform diagnostic tests and render treatment to_____.

As of this date, I have the legal right to select and authorize healthcare services for the minor child named above.

Date:_____ Signature:_____

Printed Name:_____

Relationship to Patient:_____

Witness:_____