Chiropractic Spine & Sports Medicine

Dr. Scott F. Gillman

CONSENT TO TREATMENT
OF MINOR CHILD

I hereby authorize Dr. Scott F. Gillman and/or his staff to provide professional services to my:
[ ] SON [ ] DAUGHTER

Full Name of Child: _____

Address: _____

_____

Date of Birth: _____

Date: _____ Parent or Guardians Signature: _____

Print Name: _____

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