**Patient Data**

Patient Name

Date of Birth Phone Number

Address

Number and street

City State Zip

**Insurance Information**

Primary Insurance Name/Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Responsible Party/Guarantor for Visit**  **\*This Section Must be Completed if Patient is a Minor** |

Name of Responsible Party

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle Suffix

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number & Street City State Zip Code

Main Phone ( ) Alternate Phone ( )

**Child/Adolescent Consent for Treatment**

I hereby request and authorize the staff of Family Medical Center of Michigan, using the facilities of Family Medical Center of Michigan and or off-site Immunization Clinic/s performed by Family Medical Center of Michigan staff, to administer any immunization(s) and/or any treatment deemed necessary and advisable for my child’s care until revoked in writing.

Signature: Date: