Parent or Legal Guardian please complete this form if patient is under 19 and/or a full-time college student

Mother's Name:_____ Father's Name: _____

Mother's Address:_____ Father's Address:_____

City/State/Zip:_____ City/State/Zip:_____

Mother's Date of Birth:_____ Father's Date of Birth:_____

Mother's Social Security #:_____ Father's Social Security #:_____

Mother's Home Phone #:_____ Father's Home Phone #:_____

Mother's Work Phone #:_____ Father's Work Phone #:_____

Mother's Cell Phone #_____ Father's Cell Phone #:_____

Mother's Employer:_____ Father's Employer:_____

Employer's Address:_____ Employer's Address:_____

_____ _____

Guarantor of this Account: Yes_____ No_____ Guarantor of this Account: Yes_____ No_____

The above named patient has a condition requiring diagnosis and treatment and I hereby consent to such diagnostic procedures and treatment as judged necessary by the physicians of New West Sports Medicine & Orthopaedic Surgery, P.C.

_____ _____ _____

Signature of Legally Responsible Representative **Date** **Relationship to patient**