

Minor Patient's Parent Information

Information Regarding Mother of Minor Patient:

LAST	FIRST	MIDDLE
Name:		
Address:		
City:	State:	Zip Code:
Telephone Number: ()		
Employer:		
Employer's Phone Number:		
Address of Employer:		
Social Security Number:		
Date of Birth:		

Information Regarding Father of Minor Patient:

LAST	FIRST	MIDDLE
Name:		
Address:		
City:	State:	Zip Code:
Telephone Number: ()		
Employer:		
Employer's Phone Number:		
Address of Employer:		
Social Security Number:		
Date of Birth:		

Disclosure statement for minors:

I hereby authorize McHenry County Orthopaedics, S.C. to treat my minor son/daughter,

_____ (Minor's Name)

Signed X _____