Southern Dominion Health System, Inc.

PATIENT REGISTRATION FORM
Please Fill In All Information

Authorization for Medical Treatment of Minors

Name of Minor	Birthdate	Allergies or Special Conditions

I/We being the parent(s) or legal guardian(s) of the above named minor(s) do hereby appoint:

Name	Address	Phone Number

to act in my/our behalf in authorizing medical, dental, surgical care and hospitalization for the above named minor(s) during my absence from:

Month/Day/Year	Through	Month/Day/Year

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required:

Insurance Company / Government Program:	Policy or Contract I.D. Number:

Family Physician and / or Pediatrician, Orthopedic Surgeon, Allergist, Dentist Name and Phone Number:

Parent / Guardian Signature ______________________ Date ____________

Witness Signature______________________ Date____________