THEOBALD FAMILY CHIROPRACTIC

CONSENT FOR CARE OF MINOR

As parent/guardian of _____, I do hereby authorize and request Dr. David Theobald to perform any necessary examiniations, x-rays, and Chiropractic Care.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Print name of Parent/Guardian Date

_____ _____
Witness Date

DATE: _____

NAME: _____

ADDRESS: _____

By my signature on this form, I, do hereby state that to the best of my knowledge, I am not pregnant, neither suspected or confirmed at this time.

Patient Signature: _____