Minor Patients

If the patient is a minor, please fill out this form completely.

Child's Name:_____ Date of Birth:_____

Parent/ Guardian 1:_____
Date of Birth:_____ Primary Phone:_____
Relationship to child: _____

Parent/ Guardian 2:_____
Date of Birth:_____ Primary Phone:_____
Relationship to child: _____

In the event I am unable to bring my child to his or her appointment, the following people may accompany him or her and participate in the appointment with Cini Abraham, M.D.:

_____ Relationship_____ Phone _____

_____ Relationship_____ Phone _____

_____ Relationship_____ Phone _____

_____ Relationship_____ Phone _____

I understand that this authorization is given to provide authority to the above named agent to give consent to any and all psychiatric and psychological treatment planning such as diagnosis, medication management, labs, etc. as recommended by Cini Abraham, M.D.

I consent for my minor child to be treated by Cini Abraham, M.D. in the event they must attend an appointment alone.

Please circle one: YES NO

Parents are required to attend appointments with minor children at certain intervals. It is the responsibility of the parent to communicate pertinent clinical information to Dr. Abraham prior to the appointment if unable to attend.

Are child's parents: (Please mark one)

___ Married ___ Divorced ___ Separated ___ Never Married ___ Other:_____

Please complete the following if parents are not married or are not the legal guardian:

Who has legal custody of the child and what is their relationship to the child? _____

Are both parents involved in the child's life?_____ Financially?_____

***Please provide legal documentation of custody of child if biological parents are not married. Written documentation is required from both parents in divorce cases.**

Print Name:_____ Signature_____

Date _____

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