Steinberg Diagnostic Medical Imaging Centers

Consent to Treat Minor: Non- Invasive Procedure

Date: ________________

I, The Parent or Guardian of ____

Give My Consent For SDMI To Perform The Following Procedure:

____

In Case of Emergency, Parent / Guardian Can Be Reached at: ___________________________

Primary Insurance

Company:____Phone:_______________________

Group:_____________ Effective Date:___________ Insurance ID# _______________________________

Policyholder:________________________________ Relationship to Patient ________________________

Policyholder Social Security #: _____/_____/_____ Policyholder Birth Date:___________________ Sex __

Policyholder employer:____

Secondary Insurance

Company:____Phone:______________________

Insurance ID# _________________________Group:_____________________ Effective Date:_________

Policyholder:_____________________________________ Relationship to Patient ___________________

Policyholder Social Security #: _____/____/______ Policyholder Birth Date:____________________ Sex _

Policyholder Employer:____

I understand that I am financially responsible for all services rendered to my child.

Parent / Guardian Signature_____________________________________ Date_________________

Name of Person Accompanying Minor:____
(must be over 18 years of age)

History of Illness or
Allergies:____
____
____