Upper Hudson Valley Dermatology, PC / Schenectady Dermatology, PC
A. Neal Gregory, MD, M.P.H

Minor Consent Form

Child's Name: _____ DOB: _____/_____/_____
First Middle Last Month Date Year

Social Security Number: _____ Sex: M____ F____

Home Address: _____
Street name and number Apt #

_____
City State Zip

Legal Guardian/
Parent Name: _____ DOB: _____/_____/_____
First Middle Last Month Date Year

Home Phone: _____ Work Phone: _____

Social Security Number: _____ Sex: M____ F____

I give the medical staff at Upper Hudson Valley Dermatology, PC and/or Schenectady Dermatology, PC permission to treat:

_____ for _____ for _____
Child's Name Diagnosis # of months

_____ _____
Name and Relationship to patient Date

I will take full financial responsibility for treatment of the minor listed above.

_____ _____
Signature of Parent or Guardian Date