THE MEDICAL CENTER OF PLANO
3901 W. 15th Street
Plano, Texas 75075

I request that in my absence _____be admitted to The Medical Center of
(Full Name of Child)
Plano for diagnosis and treatment.

I request and authorize physicians, dentists and staff of The Medical Center of Plano to perform any diagnostic procedures, treatment procedures and x-ray treatments and anesthetics as may be necessary in the diagnosis and treatment of the above minor.

I have not been given a guarantee as to the results of examination or treatment. I authorize The Medical Center of Plano to dispose of any specimen or tissue taken from named person.

DATE OF CHILD'S BIRTH _____

ALLERGIES OF CHILD _____

HISTORY OF PERTINENT ILLNESSES _____

DATE OF LAST TETANUS BOOSTER _____

FAMILY PHYSICIAN _____

NEXT OF KIN TO NOTIFY _____ PHONE # _____

CLOSE FRIEND _____ PHONE # _____

GUARANTOR'S INSURANCE COMPANY _____

CARRIER (EMPLOYER) _____

CONTRACT NUMBER _____ GROUP NUMBER _____

PARENT('S) NAME(S) _____
(Please print)

HOME ADDRESS _____
Street Address City State Zip

BILLING ADDRESS _____
(If different from home address) Street Address City State Zip

HOME PHONE NUMBER _____

SIGNATURE OF PARENT _____ DATE _____

WITNESS _____
Name

_____
Relationship to Parent

_____
Street Address City State Zip