General Medical Treatment Consent Form

I hereby authorize Dr. _____ and his/her medical staff to administer such medical treatment and procedures as deemed necessary for myself (or my dependent listed below).

Patient Information

Full Name:

Date of Birth:

Address:

Contact Number:

Consent

I have been informed about the nature, purpose, benefits, and possible risks of the proposed medical treatments. I understand that I may ask questions and that I have the right to withdraw my consent at any time.

☐ I have read and understand the above information.

Signature

Patient/Guardian Signature:

Date:

Submit