



SEAPORT
ORTHOPAEDIC
ASSOCIATES

PATIENT CONSENT FORM

Patient's Name: _____

I hereby consent to be routinely treated by the doctors of Seaport Orthopaedic Associates, that are deemed necessary to evaluate and/or treat accident related injuries for myself or the patient mentioned above who is a minor. I acknowledge that no guarantees have been made as to the nature of examination and/or procedures recommended or performed. I further acknowledge that I have been given the option of having services performed at another medical facility.

If further diagnostic testing is required it is my decision whether or not to proceed with the testing recommended only once it has been fully explained to me by the physician.

Signature of Patient or Legal Guardian

Date Signed

Relationship to Patient

Date Signed

FOR FEMALE PATIENTS ONLY:

I understand that in the course of my treatment I may have x-rays (radiographs), I agree to inform the doctor or technologist if I am or may be pregnant.

Signature of Patient or Legal Guardian

Date Signed

Relationship to Patient

Date Signed

Witnessed by

Date Signed