

**GENERAL CONSENT FOR TREATMENT  
KENNETH E. BAIRD, M.D., P.A.**

Knowing that I am seeking preventive care and/or suffering from a condition requiring diagnostic, medical or surgical treatment, I do voluntarily consent to such procedures, care and to such medical, surgical or other services under the general and specific instruction of Dr. Kenneth Baird at Kenneth E. Baird, M.D., P.A., his assistants, or his designee as is necessary in his judgment. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examination by Dr. Kenneth Baird or Kenneth E. Baird, M.D., P.A.

\_\_\_\_\_  
Printed name of Patient

\_\_\_\_\_  
Signature of Patient or Parent/Legal Representative

\_\_\_\_\_  
Date

**HIPAA REQUIRES THIS MUST BE COMPLETED AT EACH VISIT**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone:  
Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature or Parent/Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness