



**Peter C. Balacuit, MD**

416 South Myrtle Avenue  
Monrovia, CA 91016  
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## GENERAL CONSENT

I hereby request and consent to diagnostic procedures, including X-rays, blood test, medical treatments, including immunizations, and dental treatments deemed advisable by the professional staff of PETER C. BALACUIT, M.D.

I acknowledge that I have this consent form and understand its contents. I have had an opportunity to discuss it, and any questions I had have been answered to my complete satisfaction.

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PATIENT'S SIGNATURE

DATE

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PATIENT / LEGAL GUARDIAN SIGNATURE

WITNESS

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## CONSENTIMIENTO GENERAL

Por este medio hago peticion y consiento en procedimientos, diagnosticos, incluyendo rayos X, exámenes de sangra, tratamiento medico y dental, incluyendo vacunas recomendadas por el personal de PETER C. BALACUIT, M.D.

Reconozco que he leído esta forma de consentimiento y entiendo su contestado. He tenido la oportunidad de discutirlo y las preguntas que he hecho se han contestado a mi entera satisfaccion.

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FIRMA DE PACIENTE

FECHA

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FIRMA DEL PADRE / MADRE / TURO LEGAL

TESTIGO