**East Valley Childrens Center** **Chart#**_____

3200 S George Dr
Tempe AZ 85282

_____
Date

**REQUIRED INFORMATION**

**Parent Primarily Financially Responsible**

Last Name: _____ First Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City/State/Zip: _____ Employer: _____

Social Security #: _____ Birthdate: _____

**Parent Secondarily Financially Responsible**

Last Name: _____ First Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City/State/Zip: _____ Employer: _____

Social Security #: _____ Birthdate: _____

**EMAIL**:

_____

**EMERGENCY CONTACT**: (not living with you)

Name: _____ Phone #: _____

**REFERRED BY**:

_____

**RELEASE OF MEDICAL INFORMATION**: My signature below authorizes East Valley Childrens Center to release any medical information necessary to process claims for insurance reimbursement and/or payment. I further authorize East Valley Childrens Center to verify the information I have provided and the payment of benefits for any services rendered directly to East Valley Childrens Center. I certify to the best of my knowledge the statements contained herein are true. I understand I am responsible for all claims and charges filed and/or incurred on behalf of my dependents, including, but not limited to copayments, co-insurance and/or deductibles, collection fees, attorney fees and/or other costs incurred by East Valley Childrens Center in relation to my dependents account.

_____
Parent/Guardian Signature

**OPTIONAL INFORMATION**

**EMERGENCY CARE**: My signature below authorizes the performance of necessary medical and/or surgical treatment of my dependents in case of illness or accident in the event either a parent or guardian can be present. Required medical/surgical treatment may be performed by a physician of East Valley Childrens Center or a licensed physician of their choice, and in the medical facility of their choice whether in the office, emergency department or hospital.

_____
Parent/Guardian Signature

**TELEPHONE MESSAGES**: My signature below authorizes East Valley Childrens Center to leave voice messages at the phone numbers I have provided. I understand messages may include appointment reminders, normal test results, requested medical advice and/or other medical information related to my dependents.

_____
Parent/Guardian Signature