East Valley Children's Center

3200 S. George Dr. , Tempe AZ 85282
WWW.EVCCKIDS.NET

Date: ____________________

Acct. No. _________________

Children:

Name ______________________ DOB ____/____/____ Name _____________________ DOB ____/____/____
Name ______________________ DOB ____/____/____ Name _____________________ DOB ____/____/____
Name ______________________ DOB ____/____/____ Name _____________________ DOB ____/____/____

Parent One (Primarily Financially Responsible)

Name ____ Date of Birth ____________________________________
Address ____ City ________________ State __________ ZIP _________
Primary Phone _________________ Cell Work Home Secondary Phone ________________ Cell Work Home
Social Security # ________________________ Employer ____
Email ________________________________ Okay to send messages and/or Financials to this address Y □ N □

Parent Two

Name ____ Date of Birth _______________________________
Address ____ City ________________ State __________ ZIP _________
Primary Phone _________________ Cell Work Home Secondary Phone ________________ Cell Work Home
Social Security # ________________________ Employer ____
Email ________________________________ Okay to send messages and/or Financials to this address Y □ N □

Insurance

Insurance Company ________________________________ Insured's Name _________________________________
ID/Subscriber No. _________________________________ Group No. _____________________________________
Insured's Date of Birth _______/_______/________ Insured's Social Security No.________________________
Employer ____ Relation to Patient _____________________________

Preferred Pharmacy ________________________________ **Pharmacy Phone** _______________________________

RELEASE OF MEDICAL INFORMATION: My signature below authorizes East Valley Children's Center to release any medical information necessary to process claims for insurance reimbursement and/or payment. I further authorize East Valley Children's Center to verify the information I have provided and the payment of benefits for any services rendered directly to East Valley Children's 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 limiited to copayments, co-insurance and/or deductibles, collection fees, attorney fees and/or other costs incurred by East Valley Children's Center in relation to my dependent's accounts.

Parent/Guardian Signature ____ Date ______________________

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 cannot be present. Required medical/surgical treatment may be performed by a physician or PNP of East Valley Children's 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/Emails: My signature below authorizes East Valley Children's Center to leave voice messages at the phone numbers I have provided or notifications to the email I have provided. I understand messages/notifications may include appointment reminders, normal test results, requested medical advice, billing statements, service estimates and/or other medical information related to my dependents.

Parent/Guardian Signature ____ Date ____________________