EAST VALLEY
DERMATOLOGY CENTER
Adult and Pediatric Dermatology

MINOR CONSENT FOR EVALUATION / TREATMENT

**** This consent is for Established Patients Only ****
New Patients that are under 18 years of age, must be accompanied by a parent/guardian on the first visit.

I, _____, give permission for _____ to be evaluated and treated by East Valley Dermatology Center. I understand that in my absence, the above named patient will be prepared to update any changes to Insurance, Demographics and/or Medical History as well as pay his/her Co-Pay, if applicable with patient's insurance, at the time services are rendered.

If you have any questions, I can be reached at _____.

This authorization is valid for 6 months from the date of signature.

Parent / Guardian Name (Print): _____

Parent / Guardian Signature: _____

Patient Name / DOB (Print): _____ DOB: _____

Date: _____

Witness Signature: _____

1100 South Dobson Road, Suite 223 ● Chandler, AZ 85286
Phone (480) 821-8888 ● Fax (480) 821-0888 ● www.evderm.com