MARYSVILLE PEDIATRICS, INC.

610 S. PLUM STREET
MARYSVILLE, OHIO 43040
(937)644-1920

Patient Name: ___________________________________ Date of Birth:___________

In the event I am unable to accompany my minor child to the office of Marysville Pediatrics or in the event I am unable to discuss medical information pertaining to my child via telephone, the people listed below are authorized to do such. I understand that if there is a co-pay involved the co-pay will be paid at the time of the office visit by whichever custodian accompanies my child. I understand that the office has the option of rescheduling my child's appointment if my child or the custodian is unable to provide current insurance information and/or any required co-pay. If the physician or staff need to speak with me I can be reached at (   ) _________- _______________.

Custodians Name	Relationship

***IF AT ANYTIME YOU NEED TO AMEND THIS LIST PLEASE ADVISE THE OFFICE AS SOON AS POSSIBLE**

Parent Signature: ______________________________________Date:_______________