EAST VALLEY E.N.T.
OTOLARYNGOLOGY/HEAD & NECK SURGERY
ALLERGY, HEARING, VOICE CARE, PEDIATRIC ENT & NASAL SURGERY
WARREN S. LINE, JR., M.D., F. A. C. S.

** NON-ACCOMPANIED CHILD OFFICE VISIT AGREEMENT **

I _____ give permission for my underage child,
(Parent/Guardian Name)

_____ to be seen by Dr. Warren S. Line, Jr., M.D.
(Child Name)

of East Valley ENT without my presence at their scheduled visit(s).

_____ _____
Parent/Guardian Signature Date

* Parent/Guardian: please present a valid, state-issued identification card to the front desk staff

ADDRESS: *191 S. BUENA VISTA STREET, SUITE #320 , BURBANK, CA 91505*
PHONE: *(818) 559-9727* ***FAX:*** *(818) 559-5514* ***EMAIL:*** *EASTVALLEYENT@AOL.COM*