Elizabeth Welch, Au.D.
Melinda Gray, Au.D.

Date: ______________________

PEDIATRIC PATIENT NAME: ______________________

Preferred Name: ______________________

Sex: ❒ **M** ❒ **F** **Date of Birth:** ______________________

Primary Care Provider: ______________________

Previous Hearing Care Provider: ______________________

PARENT/GUARDIAN: ❒ **Check this box if parent/guardian listed is the financially responsible party/insured**

Name: ______________________ **Relationship to patient:** ______________________

Address: ______________________ **City, ST, Zip:** ______________________

Primary Phone: (____) ______________________ **Alternate Phone: (____)** ______________________

Email: ______________________

RESPONSIBLE PARTY/INSURED: (if other than parent/guardian)

Name: ______________________ **Employer:** ______________________

Date of Birth: ______________________

Address: ______________________ **City, ST, Zip:** ______________________

Primary Phone: (____) ______________________ **Alternate Phone: (____)** ______________________

Insurance Provider:

Primary:______________________ Secondary:______________________

HOW DID YOU HEAR ABOUT US: (Choose all that apply)

❒ **Primary Care Provider** (listed above)

❒ **Specialist:** ______________________

❒ **Advertisement:** ______________________

❒ **Friend:** ______________________

❒ **Other:** ______________________

ANNUAL UPDATES
Mark changes above & initial below:

2017: ________ 2022: ________

2018: ________ 2023: ________

2019: ________ 2024: ________

2020: ________ 2025: ________

2021: ________ 2026: ________

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