



Elizabeth Welch, Au.D.
Paige Lyon, Au.D.
Taylor Lyon, Au.D.

Date: _____

PATIENT NAME: _____ Preferred Name: _____

Sex: M F Date of Birth: _____

Address: _____ City, ST, Zip: _____

Marital Status: _____ Employment Status: _____

Primary Phone: (____) _____ Alternate Phone: (____) _____

Email: _____

Primary Care Doctor: _____ Previous Hearing Care Provider: _____

ALTERNATE CONTACT: Check this box if alternate contact is also the primary contact for appointments.

Name: _____ Relationship to patient: _____

Primary Phone: (____) _____ Alternate Phone: (____) _____

Primary Insurance: _____ Secondary: _____

RESPONSIBLE PARTY / INSURED (if other than patient): Bill to responsible party: Yes No

Name: _____ Employer: _____

Date of Birth: _____ SSN: _____ - _____ - _____ (for insurance only)

Address: _____ City, ST, Zip: _____

Primary Phone: (____) _____ Alternate Phone: (____) _____

MEDICATIONS LIST: (REQUIRED FOR ALL PATIENTS; include dosage and frequency taken) _____

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

- Primary Care Doctor (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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