



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