Hearing Services of Franklin
A Sound Decision

Elizabeth Welch, Au.D.
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Erica Thayer, 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:

2016: _____ 2021: _____
2017: _____ 2022: _____
2018: _____ 2023: _____
2019: _____ 2024: _____
2020: _____ 2025: _____

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