Shoals Hearing Clinic, P.C.
Richard L. Gresham, Au.D.
Marilyn A. Gresham, Au.D.
Child Intake Form

Patient Information Date____________________________

Last Name ____________________________ First _______________________Middle Initial_____

Preferred Name___________________________ Gender ____________

Date of Birth ________________ Age _______ Social Security Number____________________

Mother's Name ____

Mother's Employer ______________________________________ Telephone _______________

Employer's Address ____

Father's Employer ____ Telephone_______________

Employer's Address ____

In your own words, please state the primary reason for this evaluation:

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