☙ Welcome to the Office of Dr. Amy Brooks ❧

❶ Patient Information (Confidential)

Date _____ **Age** _____

No Nicknames

Legal Name _____ **Birth date** _____
Soc. Sec. # _____ **Home Phone** _____ **Cell Phone** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
If Student, Name of School / College _____ City _____ State _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____
Pharmacy Name _____ Phone _____
Dentist _____ **Orthodontist** _____ **Physician** _____
Family Members who have been patients here _____

❷ Responsible Party *(list **Self, Parent, Legal Guardian or Power of Attorney POA**)*

Name(s) _____ Relationship to Patient _____
Address _____ **Home Phone** _____
Drivers License # _____ **Birth date** _____ **Soc. Sec. #** _____
Employer _____ **Work Phone** _____

❸ Insurance Information

As a courtesy to our patients we file insurance if the correct information is provided.
Please provide a CURRENT copy of your insurance card.
Otherwise, incorrect insurance will not be filed.

Dental Insurance
Insurance Company _____ Group # _____ ID # _____
Insurance Company Phone _____
Legal Name of Policy Holder _____ Relationship to Patient _____
Birth date _____ Soc. Sec. # _____ Date Employed _____
Name of Employer _____ Work Number _____

Medical Insurance
Insurance Company _____ Group # _____ ID # _____
Insurance Company Phone _____
Legal Name of Policy Holder _____ Relationship to Patient _____
Birth date _____ Soc. Sec. # _____ Date Employed _____
Name of Employer _____ Work Number _____

❹ **Patient/Guardian Signature** _____ **Date** _____

❺ **Healthcare Power of Attorney (POA)** _____ **Date** _____