

# ❧ Welcome to the Office of Dr. Amy Brooks ❧

<b>❶ Patient Information (Confidential)</b>		Date _____	Age _____
<u>No Nicknames</u>			
Legal Name _____	Home Phone _____		Birth date _____
Soc. Sec. # _____	Cell Phone _____		
Address _____	City _____	State _____	Zip _____
<b>Check Appropriate Box:</b> <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> 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? _____			
<b>Person to Contact in Case of Emergency</b> _____		Phone _____	
<b>Pharmacy Name</b> _____		Phone _____	
<b>Dentist</b> _____	<b>Orthodontist</b> _____	<b>Physician</b> _____	
Family Members who have been patients here _____			

<b>❷ Responsible Party</b> <i>(list Self, Parent, Legal Guardian or Power of Attorney POA)</i>			
Name(s) _____		Relationship to Patient _____	
Address _____		Home Phone _____	
Drivers License # _____	Birth date _____	Soc. Sec. # _____	
Employer _____		Work Phone _____	

<b>❸ Insurance Information</b>			
<i>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.</i>			
<b><u>Dental Insurance</u></b>			
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 _____	
<b><u>Medical Insurance</u></b>			
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 _____	

<b>❹ Patient/Guardian Signature</b> _____	<b>Date</b> _____
<b>❺ Healthcare Power of Attorney (POA)</b> _____	<b>Date</b> _____