

WE CHARGE A NO-SHOW FEE OF \$50.00 FOR ANY NO-SHOW OR CANCELLATION LESS THAN 24 HOURS



Brock A Andersen, MD
Jock Perkins, MSPAC

REASON FOR VISIT: _____

Patient: Last Name: _____ First Name: _____ MI: _____ DOB: __/__/__

Full address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ (Texts? Y/N) EMAIL* _____

SS#: _____ Gender: M/F Marital Status: _____

Responsible party: Last Name: _____ First Name: _____ MI: _____ DOB: __/__/__

Full address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ (Texts? Y/N) EMAIL* _____

SS#: _____ Gender: M/F Relationship to patient: _____

*By providing my email address I give permission to send me appointment reminders, patient information, and emails about specials and events. I understand I may unsubscribe any time, and that you will never sell or share my email with any external entity. *Check here if you do not want to receive promotional emails.* []

Insurance Subscriber: Name _____ Relationship to patient: _____ DOB: __/__/__

Preferred pharmacy (name/location): _____ **Primary care provider** _____

Medications (*with dosage*): _____

Allergies to Medications: _____

Sunscreen use Tanning bed use Family history of melanoma Pregnant or trying

Current/former smoker Do you drink alcohol (*how much*): _____

Major skin problems (*e.g. psoriasis, skin cancer*): _____

Major medical history (*e.g. diabetes, COPD*): _____

Major surgery (*e.g. organ transplant*): _____

Would you like to discuss treatment for (circle):

*acne scars *anti-aging *fine lines/wrinkles *unwanted hair *unwanted fat *dark/sun spots *stretch marks *spider veins *cellulite *uneven skin tone *uneven skin texture *lengthening eyelashes *sun protection *excessive sweating

Do we have permission to: Leave message on your answering machine? Call/Leave a message at your work? Send reminder card? Discuss your medical condition with a household member?
If yes, whom (full name)? _____ Relationship _____

Signature (patient or responsible party) _____ **Date** _____

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