



Brock A Andersen, MD
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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): _____

"I certify that the information I have provided is **true, accurate, and complete** to the best of my knowledge. I understand that any falsification or omission may affect my treatment or insurance coverage.

I acknowledge that I am either the **patient** or the **authorized representative** (e.g., legal guardian or power of attorney) with the legal authority to provide this information and sign this form on the patient's behalf."

Signature (patient or responsible party) _____ Date _____

Relationship to Patient (if applicable) _____