



Brock A Andersen, MD
Thad Wilkey, PA-C
Hailey Alexander, PA-C
Tea Hasanovic, PA-C

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: _____

I hereby consent to receive text messages at the number provided, including appointment reminders. Standard message and data rates may apply.

*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) _____