Bellingham Dermatology Clinic
www.BellinghamDerm.com

Elizabeth M. Vennos, M.D.
Dermatologist, Board Certified

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Bellingham, WA 98226
360-756-0802 Fax

www.Bellingham Derm.com

Patient:

Appointment:

Time:

Check in time:

Welcome back!

Please keep this page for your records.

- **FORMS**

  ☐ Please fill in every blank on each form. **Bring completed forms with you** to the appointment. (Please do not submit them in advance.) If the forms are not 100% complete, I will use part of your appointment time to complete them for you, and I will have more time to address your problem.

  ☐ If you have had ANY treatment for the **skin** condition you wish to have addressed, bring a list of EVERY medication and product you have EVER used if it is a **new** problem for me, **and** the **dates** used. Include all over-the-counter products. Please call your pharmacy if you cannot remember all your prescriptions. If there is a questionnaire included with these documents, please use the form to document the details of your treatments.

  ☐ If the problem is **not new** to me (I have addressed it before), bring a list of EVERY medication and product you have used since the last time I address the problem.

- **FEES:** I do not contract with any insurance companies. Please **pay in full at the time of your visit**. (Cash or check welcome. **No debit, no credit**). I will give you a copy of the receipt (including insurance codes) for you to send to insurance. You may or may not be reimbursed by the insurance. If you want more info on reimbursement rates, check with your plan for your “out-of-network” benefits.

  (Note: Medicare patients may not submit a claim directly to Medicare and Medicare will NOT REIMBURESE for my services.)

  There may be a $50 late-cancellation (less than 48hrs) or no-show fee.

- **I RESPECT YOUR TIME.** Please plan on being in the office for AT LEAST ONE HOUR after your appointment time for EACH visit. (This is not the actual amount of time with the doctor.) If there are any procedures, the visit may be longer.

- Please Identify **ONE MAIN ISSUE** PER VISIT**.** If I can thoroughly address this problem in the time allowed, I may address an additional issue (s).

Thank you for choosing me for your care.

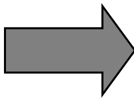
Dr. Vennos

Elizabeth M. Vennos, M.D.
Board Certified Dermatologist

Patient Last Name First

PRIVACY POLICY

I have read the US Government's Medical Record Privacy Policy (HIPAA) (available on the web and in our office.)


Signature: ____ Dated: ____________________

CANCELLATION POLICY

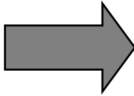
I understand that I may be charged a fee by Bellingham Dermatology Clinic for missed appointments or appointments that are cancelled or rescheduled **less than 48 hours** before the appointment time. I understand that I am directly responsible for payment of the fee and that I may not be reimbursed by my insurance company. I also understand that I may or may not receive a reminder call for future appointments.

The fee for a missed or late cancelled/rescheduled appointment is a minimum of **$50 for office visit** and $100 for surgeries.

I understand that if I am billed a cancellation fee, I will not be able to reschedule an appointment or be treated at Bellingham Dermatology Clinic until such fee is paid.

To prevent this charge please notify our office **at least 48 hours in advance,** if you are unable to keep your appointment.

By my signature below, I acknowledge that I have read and understand the cancellation policy.


Signature: ____ Dated: ____________________

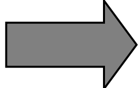
PAYMENT POLICY

- I UNDERSTAND THAT Dr. Vennos is NOT contracted with any insurance companies nor with Medicare. This means that I may not receive ANY reimbursement for services provided by Dr. Vennos if my insurance does not provide "out-of-network" benefits. I understand that I may not submit a claim for Dr. Vennos' services to Medicare.
- PAYMENT IS REQUIRED IN FULL AT THE TIME OF SERVICE, unless I have made other arrangements with this office prior to receiving services.

If you have any questions about the cost of your visit, please ask the doctor before receiving any treatment.

PAYMENT CONTRACT

- I have read, understand, and agree to the above payment policy.
- I authorize the doctor to release any information requested by my insurance company to process all claims.


Signature: ____________________________________ Date: __________________________

Px

Allg

Elizabeth M. Vennos, M.D.

Welcome Back!

New Patient Information - ADULT

LAST Name	FIRST	How do you wish to be addressed? (First name/Nickname or Mr/ Mrs/ Ms)	BIRTH Date			Gender
			M	D	Y	M F Other:

Mailing ADDRESS	City	State/Province	Zip/Postal	

Home PHONE	Cell PHONE	Work PHONE	Email
( ) ☐ None	( ) ☐ None	( ) ☐ None	☐ None
OK to leave confidential message? ☐ Yes ☐ No	OK to leave confidential message? ☐ Yes ☐ No	OK to leave confidential message? ☐ Yes ☐ No	OK to leave confidential message? ☐ Yes ☐ No

Current Employer	Full time student?	What do (did) you do for work?	Soc Sec #	
☐ Unemployed ☐ Retired	☐ Yes ☐ No	☐ N/A	Last FOUR numbers:	

EMERGENCY CONTACT Name	Relationship	What do (did) they do for work?	Best phone #	
	☐ Spouse ☐ Other:			

Primary INSURANCE (important)	Other Insurance?	Does your insurance cover prescriptions?	
☐ I have no insurance	☐ None	☐ Yes ☐ No ☐ Don't know ☐ N/A	

MAIN REASON FOR VISIT Give only one. (We may schedule for any others.)	2nd Reason	3rd Reason		
	☐ None	☐ None		

PRIMARY CARE Provider: LAST Name / FIRST Name	Degree:	Address if not local:	May we contact your provider?	
☐ None	MD – DO – ARNP - PA - NP ☐ N/A	☐ N/A	☐Yes ☐ No ☐N/A	

Date completed: ____________________

Entered by:

Patient
Last Name First

Date: _______________

Prescription MEDICATIONS (Current)		
☐ None		

Are you ALLERGIC TO?	
Medications	**On my Skin:**
☐ None	☐ Nothing

Do you have ***NOW***, or have you ***EVER HAD*** any of the conditions below? **Circle "yes" OR "no"** (If yes**,** explain).

Condition			Condition		
Asthma	NO YES	________	Stomach problem	NO YES	________
Bronchitis	NO YES	________	Bowel/Colitis	NO YES	________
Sinus Problems	NO YES	________	Hepatitis	NO YES	________
Seasonal Allergies	NO YES	________	Thyroid problem	NO YES	________
Pacemaker	NO YES	________	Glaucoma	NO YES	________
HIV positive	NO YES	________	Arthritis	NO YES	________
			Fainting	NO YES	________
Smoke history	NO YES	________	Stroke	NO YES	________
High Blood Pressure	NO YES	________	Mental Illness	NO YES	________
Phlebitis/Blood Clots	NO YES	________	Depression	NO YES	________
Cancer (not skin)	NO YES	________	Surgery (past 5 yrs.)	NO YES	________
Lupus	NO YES	________	Cold Sores/Herpes	NO YES	________
Anesthesia problems	NO YES	________	WOMEN are you:		
Excessive Alcohol	NO YES	________	Pregnant	NO YES	________
Kidney problem	NO YES	________	Nursing	NO YES	________

Condition		
Skin cancer	NO YES	If "yes", **what type**? (e.g., basal, squamous, melanoma)**:** ________
Skin removed (Biopsy)	NO YES	If "yes", body **site** & **result**: ________
Bad Sunburn	NO YES	If "yes", **how many**? ________
Eczema	NO YES	If "yes**", when**? ________
Psoriasis	NO YES	If "yes", **when**? ________
Other skin Problems	NO YES	If "yes", **what**? ________
Family: skin cancer	NO YES	If "yes", **who & what type**? (e.g., basal, squamous, melanoma) ________
Family: eczema, asthma or allergies (Circle all that apply)	NO YES	If "yes", **details** ________

List any other conditions: ________

Completed by: ☐ Patient ☐ Other________

Returning pt pkt - NO Q 06-17-23