Bellingham Dermatology Clinic
www.BellinghamDerm.com

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

2075 Barkley Blvd, Suite 225
Bellingham, WA 98226
360-756-0802 Fax

www.Bellingham Derm.com

Patient:

Appointment:

Time:

Check in time:

Welcome!

Please keep this page for your records.

Please read the following information to assist in preparing for your first visit:

- **FORMS**

  ☐ Please print forms as **single sided** only. **Bring completed forms with you** to the appointment. (Please do not submit them in advance.)

  ☐ Please fill in every blank on each form. 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 your **skin** condition, bring a list of EVERY medication and product you have EVER used, **and** the **dates** used. Include all over-the-counter products. Please call your pharmacy if you cannot remember all your prescriptions. If you are using one of the questionnaires, please use the form to document the details of your treatments.

- **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 the 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 (48hrs) or no-show fee.

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

- **Identify ONE MAIN ISSUE** PER VISIT**.** If I can thoroughly address this problem in the time allowed, I will consider addressing additional concerns. Please list all your concerns on the form attached, so that I may more efficiently plan my time with you.

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 to Our Office!

Patient Information – MINOR

LAST Name	FIRST	Nickname	M.I.	Gender	BIRTH Date		
				M F	M	D	Y

Mailing ADDRESS	City	State/Province	Zip/Postal	

Home PHONE	Patient Cell PHONE (if any)		Family Email	Soc Sec#
( ) ☐ None OK to leave confidential message? ☐ Yes ☐ No	( ) ☐ None OK to leave confidential message? ☐ Yes ☐ No		☐ None OK to leave confidential message? ☐ Yes ☐ No	Last FOUR numbers:

MOTHER LAST Name	FIRST	Occupation	Best Phone #	

FATHER LAST Name	FIRST	Occupation	Best phone #	

Primary INSURANCE	Other Insurance	Does your insurance cover prescriptions?	
☐ Pt has 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	Has patient or parent met Dr. Vennos before?	
	☐ None	☐ None	☐ Yes ☐ No If "yes", how?	

PRIMARY CARE Provider		Degree:	Address:	May we contact your provider?	
LAST Name	FIRST Name	MD – DO – ARNP - PA - NP		☐ Yes ☐ No	
☐ None		☐ N/A	☐ N/A	☐ N/A	

How did you learn about Dr. Vennos? (Chose ONE)

☐ Primary care (as above)	☐ another provider (name): MD – DO - ARNP- PA – NP	☐ Other: Entered by:

Date completed: _____

OVER

AUTHORIZATION TO TREAT MINOR

Any child under the age of 13 **will not** be seen without a parent or guardian present. If someone else accompanies the child, **written consent must be presented** with this person's name at the time of visit authorizing consent to evaluate and treat.

PATIENT: _____

I consent to have Dr. Vennos treat my child when I am NOT present:

- ❒ No
- ❒ Yes

IF YES . . . I want a follow-up call after each visit:
Please check one:

- ❒ No
- ❒ Yes

PARENT or
LEGAL GUARDIAN: _____ DATE: _____
(signature)

Elizabeth M. Vennos, M.D.
Dermatologist
(360) 647-2188

L

Date: _____

Patient
Last Name First

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).

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	_____

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_____ New MINOR pt packet NO Q 06-17-23