Bellingham Dermatology Clinic
www.BellinghamDerm.com

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

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www.Bellingham Derm.com

Welcome to our practice!

Please keep this page for your records.

Please read the following information to assist you in preparing for your first visit at our office:

- **FORMS**

  ☐ Please print forms as single sided only.
  ☐ Please fill in every blank on each form. If the forms are not complete, the doctor will use your appointment time to complete them for you. If they are complete, she will spend 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 received a questionnaire about your problem, please use the form to document the details of your treatments.

- **OUR FEES:** We do not contract with any insurance companies. Please **pay in full at the time of your visit**. (Debit, credit, cash, or check welcome). We will give you a copy of your receipt (including insurance codes) for you to send on your own to your insurance. You may or may not be reimbursed by your 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.) There is a $50 late-cancellation (48hrs) or no show fee.

- **WE RESPECT YOUR TIME.** So that you may plan your day effectively, please plan on being in our 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, you may be here longer.

- **ONE PROBLEM** PER VISIT**.** We ask you to choose one problem per visit. If Dr. Vennos can thoroughly address this problem in the time allowed, she will consider addressing any others. Please list all your concerns on the form attached, so she may more efficiently plan her time with you.

Thank you for choosing us for your care. We look forward to caring for you.

Patient Name

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

PRIVACY POLICY

I have read the Medical Record Privacy Policy (HIPPA) posted in waiting area, also available on the web site.

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	☐ N/A	☐ Yes ☐ No	
☐ None		☐ N/A		☐ N/A	

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

☐ Provider ☐ Primary care (as above) ☐ Or other provider (name): MD – DO - ARNP- PA - NP	☐ Provider's office staff Provider:	☐ Another patient Name: May we send thanks? □ Yes □ No	☐ Friend	☐ Yellow pages **Whatcom** ☐ Dex ☐ Plaid **Skagit** ☐ Dex ☐ Plaid	☐ Website	☐ Other (explain):

Entered by:

Date completed: _____

OVE

AUTHORIZATION TO TREAT MINOR

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

Many times parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

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

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Patient Name

Date: _____

Oral MEDICATIONS (Current)		
☐ None		

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** _____	Bladder problem	**No**	**Yes** _____
Bronchitis	**No**	**Yes** _____	Stomach problem	**No**	**Yes** _____
Sinus problem	**No**	**Yes** _____	Bowel/Colitis	**No**	**Yes** _____
Seasonal allergy	**No**	**Yes** _____	Hepatitis	**No**	**Yes** _____
Pacemaker	**No**	**Yes** _____	Thyroid problem	**No**	**Yes** _____
HIV positive	**No**	**Yes** _____	Glaucoma	**No**	**Yes** _____
IV Drug use	**No**	**Yes** _____	Arthritis	**No**	**Yes** _____
Smoking history	**No**	**Yes** _____	Seizures	**No**	**Yes** _____
High blood pressure	**No**	**Yes** _____	Fainting	**No**	**Yes** _____
Heart attack	**No**	**Yes** _____	Stroke	**No**	**Yes** _____
Phlebitis/blood clots	**No**	**Yes** _____	Mental Illness	**No**	**Yes** _____
Cancer (not skin)	**No**	**Yes** _____	Depression	**No**	**Yes** _____
Lupus	**No**	**Yes** _____	Surgery (past 5 years)	**No**	**Yes** _____
Artificial joints	**No**	**Yes** _____	Cold Sores/Herpes	**No**	**Yes** _____
Anesthesia reaction	**No**	**Yes** _____			
Excessive alcohol	**No**	**Yes** _____	**Women** are you:		
Kidney problem	**No**	**Yes** _____	Pregnant	**No**	**Yes** **DUE DATE:**
Diabetes	**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**: _____
Tanning booth use	**No**	**Yes** If "yes", **# of times**:_____
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_____ **Reviewed by**: Dr_____

NEW

Problem
(Est or NP)

Patient Name

Date_____

Directions:

1. Please complete this form if you have a skin condition. For example: a rash or rash-like area(s), acne or possible skin infection. Do not use this form for simple spots, lesions, moles, etc. (no questionnaire necessary)
2. **ONE skin problem per form**. (Use additional forms, if more than one problem.)
3. **Fill in every blank**.

Describe your problem (E.g. rash, spots, bumps, etc)		Office Use Only
Location of problem (E.g. back, face, arms, legs)		
Date problem <u>first</u> ever started	Month _____ Day _____ Year _____	
Have any tests done for this problem? (E.g. a skin sample, blood tests, etc.)	☐ Yes, result ☐ No	
Feel of skin problem (E.g. itch, sore, rough, burning)	☐ Feels normal	
Look of skin problem E.g. color, shape	☐ Looks normal	
Has problem ever gone away?	☐ No ☐ Yes, when:	
Name brand of **soap (s) or shampoo** used on problem area	☐ No soap ever used	
Name brand of **moisturizer (s)** used on problem areas	☐ No moisturizer ever used	

Anything else you want the doctor to know about **this** problem:

List all Treatments and Products
Current and prior for <u>this skin problem only</u>.

☐ I have had NO treatments of any kind for this problem.

NAME of each product Include: • Prescriptions • Over-the-counter • Any other treatment	**TYPE** of product E.g.: • pill • cream • ointment • gel • liquid • cleanser	Date **FIRST** used?	Date **LAST** used?	**HOW OFTEN** used or applied? Eg. Daily Weekly	Office Use
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					