



## 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.

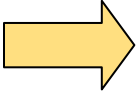
Thank you for choosing us for your care. We look forward to caring for you.

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

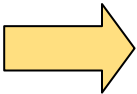
I understand that I may be charged a fee by Bellingham Dermatology Clinic for missed appointments or appointments that are cancelled or rescheduled **less than 48 hours** before the appointment time. I understand that I am directly responsible for payment of the fee and that I may not be reimbursed by 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: \_\_\_\_\_

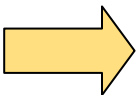
## PAYMENT POLICY

- 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

Elizabeth M. Vennos, M.D.  
**Welcome to Our Office!**  
Patient Information – MINOR



Allg

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#
( ) <input type="checkbox"/> None OK to leave confidential message? <input type="checkbox"/> Yes <input type="checkbox"/> No	( ) <input type="checkbox"/> None OK to leave confidential message? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> None OK to leave confidential message? <input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Pt has no insurance	<input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> N/A

MAIN REASON FOR VISIT Give only one. (We may schedule for any others.)	2 <sup>nd</sup> Reason	3 <sup>rd</sup> Reason	Has patient or parent met Dr. Vennos before?
	<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", how?

PRIMARY CARE Provider		Degree:	Address:	May we contact your provider?
LAST Name	FIRST Name	MD – DO – ARNP - PA - NP	<input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> None		<input type="checkbox"/> N/A		<input type="checkbox"/> N/A

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

<input type="checkbox"/> Provider <input type="checkbox"/> Primary care (as above) <input type="checkbox"/> Or other provider (name):  MD – DO - ARNP- PA - NP	<input type="checkbox"/> Provider's office staff Provider:  <input type="checkbox"/> N/A	<input type="checkbox"/> Another patient Name: May we send thanks? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Friend	<input type="checkbox"/> Yellow pages <b>Whatcom</b> <input type="checkbox"/> Dex <input type="checkbox"/> Plaid <b>Skagit</b> <input type="checkbox"/> Dex <input type="checkbox"/> Plaid	<input type="checkbox"/> Website	<input type="checkbox"/> Other (explain):
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Date completed: \_\_\_\_\_

Entered by:



# 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

Patient Name \_\_\_\_\_

Date: \_\_\_\_\_

Oral MEDICATIONS (Current)		
<input type="checkbox"/> None		

ALLERGIC TO:	
Medications	On my Skin:
<input type="checkbox"/> None	<input type="checkbox"/> 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** \_\_\_\_\_
- Bronchitis **NO YES** \_\_\_\_\_
- Sinus problem **NO YES** \_\_\_\_\_
- Seasonal allergy **NO YES** \_\_\_\_\_
- Pacemaker **NO YES** \_\_\_\_\_
- HIV positive **NO YES** \_\_\_\_\_
- IV Drug use **NO YES** \_\_\_\_\_
- Smoking history **NO YES** \_\_\_\_\_
- High blood pressure **NO YES** \_\_\_\_\_
- Heart attack **NO YES** \_\_\_\_\_
- Phlebitis/blood clots **NO YES** \_\_\_\_\_
- Cancer (not skin) **NO YES** \_\_\_\_\_
- Lupus **NO YES** \_\_\_\_\_
- Artificial joints **NO YES** \_\_\_\_\_
- Anesthesia reaction **NO YES** \_\_\_\_\_
- Excessive alcohol **NO YES** \_\_\_\_\_
- Kidney problem **NO YES** \_\_\_\_\_
- Diabetes **NO YES** \_\_\_\_\_

- Bladder problem **NO YES** \_\_\_\_\_
- Stomach problem **NO YES** \_\_\_\_\_
- Bowel/Colitis **NO YES** \_\_\_\_\_
- Hepatitis **NO YES** \_\_\_\_\_
- Thyroid problem **NO YES** \_\_\_\_\_
- Glaucoma **NO YES** \_\_\_\_\_
- Arthritis **NO YES** \_\_\_\_\_
- Seizures **NO YES** \_\_\_\_\_
- Fainting **NO YES** \_\_\_\_\_
- Stroke **NO YES** \_\_\_\_\_
- Mental Illness **NO YES** \_\_\_\_\_
- Depression **NO YES** \_\_\_\_\_
- Surgery (past 5 years) **NO YES** \_\_\_\_\_
- Cold Sores/Herpes **NO YES** \_\_\_\_\_

**Women are you:**  
 Pregnant **NO YES DUE DATE:** \_\_\_\_\_  
 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 **NO YES**  
 (circle all that apply) \_\_\_\_\_

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

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

## List all Treatments and Products Current and prior for this skin problem only.

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

<b>NAME</b> of each product  Include: <ul style="list-style-type: none"> <li>• Prescriptions</li> <li>• Over-the-counter</li> <li>• Any other treatment</li> </ul>	<b>TYPE</b> of product E.g.: <ul style="list-style-type: none"> <li>• pill</li> <li>• cream</li> <li>• ointment</li> <li>• gel</li> <li>• liquid</li> <li>• cleanser</li> </ul>	Date <b>FIRST</b> used?	Date <b>LAST</b> used?	<b>HOW OFTEN</b>  used or applied?  Eg. Daily Weekly	Office Use
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					