Px

Elizabeth M. Vennos, M.D.

Welcome Back to Our Office!

Patient Information – ADULT-3 yr Update

Allg

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

Mailing ADDRESS	City	State/Province	Zip/Postal	

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

Current Employer	Full time student?	What do (did) you do for work?		
□ Unemployed □ Retired	□ Yes □ No	□ N/A		

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

Primary INSURANCE (important)	Other Insurance	Deductable amt	Rx coverage?	
□ No insurance	□ None	□ N/A □ Don't know	□ Yes □ No □ Don't know	

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	

Entered by:

Date completed: _____

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:_____

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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	**No**	**Yes**	_____
Bronchitis	**No**	**Yes**	_____	Stomach	**No**	**Yes**	_____
Sinus Problems	**No**	**Yes**	_____	Bowel/Colitis	**No**	**Yes**	_____
Seasonal Allergies	**No**	**Yes**	_____	Hepatitis	**No**	**Yes**	_____
Pacemaker	**No**	**Yes**	_____	Thyroid	**No**	**Yes**	_____
HIV positive	**No**	**Yes**	_____	Glaucoma	**No**	**Yes**	_____
				Arthritis	**No**	**Yes**	_____
Smoke	**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 Problems	**No**	**Yes**	_____				
Excessive Alcohol	**No**	**Yes**	_____	**Women** are you:			
IV Drug Use	**No**	**Yes**	_____	Pregnant	**No**	**Yes**	If "yes", due date:
Diabetes	**No**	**Yes**	_____				_____
Kidney	**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_____ F:\Practice Files\FORMS\PATIENT related forms\Med Hx 11-30-2014.doc **Reviewed by**: D r_____

ESTABLISHED

Problem

Name: _____
Date_____

*Date of last visit for this problem:

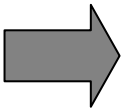
Directions:

1. Please complete this form for your skin condition that Dr. Vennos has addressed before. 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**.

Name of your problem (E.g. rash, spots, bumps, etc)	☐ Don't know name	Office Use Only
Location of problem (E.g. back, face, arms, legs)		
Improvement since last visit*?	☐ No ☐ Minimal ☐ Much improved ☐ Resolved/ cleared up	
Feel of skin problem (E.g. itch, sore, rough, burning)	☐ Feels normal	
Look of skin problem E.g. color, shape	☐ Looks normal	
Name brand of **soap (s) or shampoo** used on problem area	☐ No soap used since last visit	
Name brand of **moisturizer (s)** used on problem areas	☐ No moisturizer used since last visit	

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

Next page.



ALL TREATMENTS
Since your <u>last visit for this problem</u> only:

☐ I have had NO treatments of any kind since the last visit 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.					
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