Bellingham Dermatology Clinic
www.BellinghamDerm.com

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

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Bellingham, WA 98226
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www.Bellingham Derm.com

Patient:

Appointment:

Time:

Check in time:

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**. (Cash or check welcome. **No debit, no credit**). We 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 our services.) 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, the visit time may be longer.

- **Identify ONE MAIN ISSUE** 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.

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

Patient
Last Name First

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!

New Patient Information - ADULT

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 Other:	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?	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	

			Do you want skin cancer **screening** today?	Have you met Dr. Vennos before?
MAIN REASON FOR VISIT Give only one. (We may schedule for any others.)	2nd Reason	3rd Reason	☐Yes ☐ No ☐ Don't know	☐ Yes ☐ No If "yes", how?
	☐ None	☐ None		

PRIMARY CARE Provider:		Degree:	Address if not local:	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 box)

☐ 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	☐ Website	☐ Other (explain):

Entered by:

Date completed: _____

Patient
Last name FIRST

Date:

THE SKIN CANCER SCREENING EXAM

What is it?

On your **first** visit, Dr. Vennos offers a complete skin exam to screen for skin cancer. This exam is offered **without an additional charge** and is offered only on the first visit. It may not be delayed until a later visit.

For this exam you will **remove all your clothing (**undergarments may remain on) and put on a privacy gown and/or drape. The exam takes less than 5 minutes, and the doctor will scan the skin looking for any suspicious areas. She will then discuss these areas with you and make recommendations for treatment if necessary.

LADIES

If you wish to have the screening include the **face**, **all makeup must be thoroughly removed.**

Please use **soap** and water.

If you do not wish to remove your makeup, please indicate here:

☐ I do not wish to remove my make-up, and I understand that I will not have my face checked for skin cancer.

I want the screening exam (circle) YES NO

L

Patient Name

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).

Asthma	NO	YES	_____	Bladder problem	NO	YES	_____
Bronchitis	NO	YES	_____	Stomach problem	NO	YES	_____
Sinus Problems	NO	YES	_____	Bowel/Colitis	NO	YES	_____
Seasonal Allergies	NO	YES	_____	Hepatitis	NO	YES	_____
Pacemaker	NO	YES	_____	Thyroid problem	NO	YES	_____
HIV positive	NO	YES	_____	Glaucoma	NO	YES	_____
				Arthritis	NO	YES	_____
Smoke 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 yrs)	NO	YES	_____
Anesthesia Problems	NO	YES	_____	Cold Sores/Herpes	NO	YES	_____
Artificial Joints	NO	YES	_____				
Excessive Alcohol	NO	YES	_____	WOMEN are you:			
Diabetes	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**: _____
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_____

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:

Turn over
to other side.

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.					