WELCOME TO OUR OFFICE

TODAY'S DATE_____

IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.
ALL INFORMATION IS STRICTLY CONFIDENTIAL.

PATIENT'S NAME _____ BIRTHDATE _____
(Last) (First) (Middle) (Month, Date, Year)

SOCIAL SECURITY #_____ MARITAL STATUS _____

ADDRESS _____ ZIP CODE _____
(Street) (City)

HOME PHONE ( ) _____ **WORK PHONE** ( ) _____

CELL PHONE ( ) _____ **E-MAIL**_____

RACE (Please circle): WHITE AMERICAN INDIAN OR ALASKA NATIVE ASIAN BLACK OR AFRICAN-AMERICAN NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER OTHER RACE

ETHNICITY (Please circle): HISPANIC OR LATINO NOT HISPANIC OR LATINO

EMPLOYER _____ ADDRESS _____

NAME OF SPOUSE (OR PARENT) OF THE INSURED _____

BIRTHDAY_____ PHONE _____

I hereby authorize medical providers and personnel of Northshore Dermatology Center to contact me regarding appointments, lab and pathology reports, surgical information and billing.
If you are not available at the time we try to call you, may we:

DISCLOSE MEDICAL INFORMATION ON AN ANSWERING MACHINE (PLEASE CIRCLE): **YES NO**

LEAVE APPOINTMENT INFORMATION ON AN ANSWERING MACHINE (PLEASE CIRCLE): **YES NO**

The following person(s) can inquire, pick up records, prescriptions, x-rays, etc., and take messages regarding my health information.(Please include any Physicians, friends or relatives to whom you may allow to take part in caring for your health.)

1._____ Relationship_____

2._____ Relationship_____

3._____ Relationship_____

It is the responsibility of the patient to contact us with any changes to the above information in writing.

I HEREBY ACKNOWLEDGE RECEIPT OF THE PHYSICIAN'S NOTICE OF PRIVACY PRACTICES. THE NOTICE OF PRIVACY PRACTICE PROVIDES DETAILED INFORMATION ABOUT HOW THE PRACTICE MAY USE AND DISCLOSE MY CONFIDENTIAL INFORMATION.
I UNDERSTAND THAT THE PHYSICIAN HAS RESERVED A RIGHT TO CHANGE HIS OR HER PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE. I ALSO UNDERSTAND THAT A COPY OF ANY REVISED NOTICE WILL BE PROVIDED TO ME OR MADE AVAILABLE.

PLEASE SIGN. THANK YOU.

SIGNED: _____ **DATE:**_____
(if you are not the patient, please specify your relationship to the patient)

NORTHSHORE DERMATOLOGY CENTER, S.C.
PATIENT FINANCIAL POLICY

TINA C. VENETOS, M.D.
Licensed Dermatologist

AMY C. BROWNLEE, M.S., P.A.-C.
Licensed Dermatology Physician Assistant

Northshore Dermatology Center has contracts with many insurance plans. Please check with your insurance carrier to determine whether we participate in your specific plan.

If we are contracted with your plan, we will file a claim (for non-cosmetic services) to your insurance company. You will be responsible for any co-pays, deductibles, purchased products and/or non-covered services.

Returned checks will be subject to additional fees and interest charges ($25 per check).
Balances older than 90 days will be sent to a collection agency.

If you do not have one of the plans which the practice is contracted, the total cost of the visit is required at the time of service.

A separate charge for pathology and lab work may be submitted to your insurance company in addition to the procedure itself. Any charges not covered by your insurance company will be your responsibility.

Many plans, including HMO and POS plans, require referral authorization from your Primary Care Provider (PCP) in order for your visit with us to be covered. If you did not obtain a referral prior to your appointment, you will be asked to pay at the time of service.

All laser and cosmetic appointments rendered in our office require payment in full at the time of service. We do not bill these services, even if your plan is one with which we are contracted, as they are deemed "elective" and not medically necessary.

For your convenience, we accept cash, checks, Visa, Master Card and Discover as payment options. If you have any question about coverage and/or payment, feel free to ask in advance of services being rendered.

At Northshore Dermatology Center, we are dedicated to providing you with the highest quality care, including privacy. We abide by HIPPA regulations to ensure patient confidentiality at all times. We protect the security and confidentiality of your personal information. Our most important asset is our relationship with you.

I hereby acknowledge that I have read this document and understand my financial responsibility for services provided for myself and other patients whose names I have provided to appear on my account with Northshore Dermatology Center.

Signed _____ **Date** _____

NORTHSHORE DERMATOLOGY CENTER, S.C.

Tina C. Venetos, M.D.
Amy C. Brownlee, MS, PA-C

SECURE CREDIT CARD INFORMATION

Northshore Dermatology Center requires patients to keep a credit card on file to pay any balance due after insurance has made payment to us (includes both primary and secondary insurance companies). This card will be used only to charge the balance due on the patient's account (co-payments, co-insurance amounts and deductibles). We will send you two invoices and wait for payment. If no payment is received within 14 days after two statements were sent, we will charge your card for the balance due.

Itemized receipts will be mailed to you for any charges made on your card.

Your credit card information is kept on file in our HIPPA compliant electronic practice management software.

By signing this form, I authorize Northshore Dermatology Center to charge co-pays and any outstanding balances on my account to the credit card kept on file.

_____ _____

Patient Signature Date

925 Sherwood Dr. Rd.
Lake Bluff, IL
60044 - 60048

Phone: 847-234-1177
Fax: 847-234-1875

3612 W. Lake Ave. Suite 2B
Wilmette, IL 60091

Phone: 847-853-7900
Fax: 847-853-9847

1880 W. Winchester Suite 107
Libertyville, IL

Phone: 224-433-6423

Patient Name: _____

Pharmacy: _____ City:_____

Primary Care/Family Physician:_____ Phone:_____

Referring Physician:_____ Phone:_____

Past Medical History (Check all that apply)**:**

- ☐ Anxiety
- ☐ Arthritis
- ☐ Atrial Fibrillation *(Irregular Heartbeat)*
- ☐ Bone Marrow Transplant
- ☐ BPH *(Benign Prostate Hyperplasia)*
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD *(Acid Reflux)*
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension *(High Blood Pressure)*
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia *(High Cholesterol)*
- ☐ Hyperthyroidism *(Overactive Thyroid)*
- ☐ Hypothyroidism *(Underactive Thyroid)*
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ **Other:**_____

Skin Disease History (Check all that apply)**:**

Do you wear sunscreen? Yes__ No__ If yes, what SPF?_____

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ **Other:**_____

Do you tan in a tanning salon? Yes__ No__

Medications: Please list all medications that you are taking and their dosage

Allergies: Please list all drug, anesthetic (numbing medication), tape, latex, iodine, or food allergy

Social History:

(Check all that apply)

Smoking Status: Current___ Former___ Never____

Alcohol Use: None___ Less than 1 drink per day___ 1-2 drinks per day____ 3 or more drinks per day____

Family History:

(Check all that apply and indicate family member relation)

- ☐ Non melanoma skin cancer_____
- ☐ Melanoma _____
- ☐ Asthma _____
- ☐ Psoriasis_____
- ☐ Eczema_____
- ☐ Acne_____
- ☐ Hypertension_____
- ☐ Heart disease_____
- ☐ Breast cancer_____
- ☐ Diabetes, type 1_____
- ☐ Diabetes, type 2_____
- ☐ **Other:**_____

Alerts:

(Check all that apply)

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within the past two years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ History of melanoma
- ☐ MRSA
- ☐ Pacemaker
- ☐ Pregnancy or planning a pregnancy
- ☐ Premedication before procedures
- ☐ Rapid heartbeat with epinephrine

Patient Signature:_____ **Date:**_____