George Kouris, MD

Aesthetic & Reconstructive Plastic Surgeon

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Hinsdale, Il. 60521

708-354-4667
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1611 W Harrison St. Suite 212
Chicago, Il 60612

Today's Date _____

PATIENT INFORMATION:

Patient Name: _____ Sex: **F** **M**

Address: _____ Birth Date: _____

City Zip _____ Age: _____

Home Phone: _____ SS#: _____

Work Phone: _____ Marital Status: **S** **M** **W** **D**

Cell Phone: _____ Height: _____ Weight: _____

Email: _____

WHAT IS YOUR REASON FOR THIS VISIT? _____

PHYSICIAN / EMERGENCY INFORMATION:

Family Physician: _____ Office #: _____

Address: _____

_____

Emergency Contact: _____ Phone #: _____

Relationship: _____

Who referred you to Dr. Kouris? _____ Phone #: _____

Spouse Name: _____ Spouse Birth Date: _____

PHARMACY INFORMATION:

Pharmacy Chain: _____ Phone #: _____

ALLERGIES TO MEDICATIONS:

Yes___ (Please list below) No___

Name of medication	Reaction

FAMILY HISTORY(eg cancer or hereditary diseases)

Please indicate MATERNAL or PATERNAL

Family member	Disease	Cause of death

MEDICATION (prescription, supplements, vitamins and over the counter)

NAME OF MEDICATION	REASON FOR TAKING	NAME OF MEDICATION	REASON FOR TAKING

Please circle if you take any of the following: **COUMADIN** **PLAVIX** **LOVENOX** **ASPIRIN** **IBUPROFEN**

SOCIAL HISTORY:

Do you have children? Yes___ No___ If yes, how many daughter(s)_____ sons(s)_____

Who do you live with? _____

Do you work? Yes___ No____ What type of work do you do or did you do if you are retired? _____

HEALTH HABITS:

Do you smoke or have you ever smoked cigars/cigarettes? Yes___ No___ How many per day? _____

For how long? _____ Year quit(if applicable) _____

Do you drink alcohol? Yes___ No___ How many drinks per week? _____

Have you recently used any recreational drugs? Yes___ No ___ Explain: _____

Do you consume caffeine? Yes___ No___ What type and how much per day?_____
Have you ever had a mammogram? Yes___ No___ When?_____ Results: Normal_____ Abnormal_____
Have you ever had a breast biopsy? Yes___ No___ When?_____ Side: Left____ Right____
Results: Normal:_____Abnormal:_____ Explain:_____

MEDICAL HISTORY (Please circle those that apply to you):

Diabetes	Heart Failure	Heart Murmur	Previous Heart Attack Date:_____
Irregular heart beat	Rheumatic fever	High Cholesterol	High blood pressure
Asthma	Tuberculosis	Bronchitis	Pneumonia
Emphysema	Sleep Apnea	Arthritis	Thyroid disorder
Reflux	Hiatal Hernia	Peptic Ulcer Disease	Hepatitis
Cirrhosis	Diverticulosis	Hernia	Kidney Failure
Incontinence	Stroke	Headaches	Anxiety
Depression	Anemia	HIV/AIDS	**NO KNOWN HEALTH PROBLEMS**

Cancer Type of Cancer:_____Other:_____
Do you have any metal implants? Yes___No___ Do you have a pacemaker/defibrillator? Yes:___No:___

SURGICAL HISTORY: ____No surgeries in the past

SURGERY	DATE	SURGERY	DATE

NO KNOWN HEALTH PROBLEMS

I hereby authorize the physician to treat my daughter / son / myself. (Please circle appropriately)

Patient/Parent/Guardian _____ **Date** _____

ALL INFORMATION REVIEWED WITH PATIENT/PARENT/GUARDIAN

Doctor/Staff Member _____ Date _____

George Kouris, MD

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Patient Agreement and Authorization

Consent for Treatment: I hereby consent to the treatment provided by the practice and its employees and designees. I authorize mental and physical health care services deemed necessary or advisable by my caregivers to address my needs.
Initial: _____

Consent to take photographs: I hereby authorize George Kouris, M.D. and/or his associates or licensees to take pre-operative, intra- operative and post- operative photographs, slides, and or videotapes. I additionally consent to photographs of my interview.
Initial: _____

Consent for release of photographs: I hereby authorize George Kouris, M.D. and/ or his associates or licenses to use pre- operative, intra-operative, and post- operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups. I understand my identity will not be revealed at any time. I also understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.
Initial: _____

Authorization for Release of Health Information: I authorize the use and disclosure of my personal health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my care, or for the purpose of conducting healthcare operations of the practice. I authorize the practice to release information required in the process of applications for financial coverage for the services rendered. This authorization provides that the practice may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company, its designated agent or other healthcare providers involved in my care and treatment.
Initial: _____

Authorization of Insurance Benefits/Payment Guarantee/Collection Fees: I authorize payment to be made directly to the practice for insurance benefits payable to me. I understand that I am financially responsible to the practice for any covered or non covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue amount is referred to a collection agency, I will be responsible for the costs of the collection including reasonable attorneys' fees.
Initial: _____

Privacy Policy: I acknowledge having received the practice's "Notice of Privacy Practices." My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the policy. I understand that I may revoke in writing my consent for release of my health care information, except to extent that the practice has already made disclosures with my prior consent.
Initial_____

_____ _____ _____

Patient or Authorized signature Relationship Date

_____ _____

Witness Signature Date

The patient is unable to sign; verbal consent given. Reason: _____