Specialising in:

- **Primary & revision hip and knee replacement**
- **Computer-navigated & Robot-assisted surgery**
- **Patient-specific implants systems**
- **General Orthopaedics**

PATIENT INFORMATION (please print clearly)

Mr. / Mrs. / Miss / Ms. / Dr. / Other: ___________________

Surname: ____

Given name: ______________________________________

Address: ____

____

____________________________Post Code: __________

Postal address: ___________________________________

____________________________Post Code: __________

Phone no.: Home: _________________________________

Work: _________________________________

Mobile: ________________________________

Email: ____

Date of Birth: _________ /_________ /_____________

Next of Kin: _______________________________________

Relationship: ______________________________________

Phone no.: Home: _________________________________

Work: _________________________________

Mobile: ________________________________

Family Doctor: **Dr.** ________________________________

Address: ____

____

____________________________Post Code: __________

Referring Doctor: (if different from above)

Dr. ____

Address: ____

____

____________________________Post Code: __________

A/Professor Kurmis is a preferred provider with most major private health insurance funds. It is your obligation to contact your own insurer prior to any planned treatment or surgery to ensure your fund and membership type are appropriate.

Medicare Card Number: ____________________________

Your reference number: ____________________________

(This is the number in front of your name).

Expiry Date: _________ /_____________

Do you have a Concession Card ? Yes No

Pension Card number: ______________________________

Expiry Date: _________ /_________ /_____________

Health Care Card number: ___________________________

Expiry Date: _________ /_________ /_____________

Commonwealth Seniors Card number: _________________

Expiry Date: _________ /_________ /_____________

Veteran Affairs Card number:_________________________

Gold Card Yes No

White Card Yes No

What condition does the white card cover ?

____

Do you have Private Hospital Insurance ? Yes No

Private Health Fund name: ___________________________

Membership Number: _______________________________

Is you membership current ? Yes No

Your Account: All payments for your consultation are to be made in full on the day of your visit. EFTPOS facilities are available. If you are to be booked for surgery you will be charged a co-payment which is an extra cost and is not Medicare rebateable and is not covered by Private Hospital Insurance.

Your Declaration:

☑ I have read the above information and the Privacy Statement. I agree to pay all of my accounts on the day of each visit.

☑ I also understand that failure to pay my account could incur extra charges which are payable by myself.

☑ I accept the said conditions.

Patient Signature: ____ Date: _____ / _____ / __________

Privacy Note: This Practice will collect information about you and your health under the guidelines of the National Privacy Principles 2001. Your attendance, together with your signature on this form will be taken as consent for the collection of this information. It will be used in the course of managing your healthcare and will include referral to additional specialists and allied health carers. Any unauthorised access will not be allowed without your permission. At times it will be necessary to collect health information from family members. Should you have any concerns, questions or complaints about any issue relating to privacy of your personal information, please contact A/Professor Kurmis to discuss the matter.

MEDICAL INFORMATION **It Is important that you answer all of the questions asked**

Height: _______ cms Weight: _______ kgs

Are you sensitive or **allergic** to any medicines, foods, tapes, metals, latex / rubber, antiseptics, or other items? Yes No

If yes, which ones: ___________________________________

____

Do you suffer from:

Asthma, cough, shortness-of-breath ? Yes No

Diabetes ? Type: _____ Yes No

Sleep Apnoea ? Yes No

Do you use a CPAP machine ? Yes No

Do you have high blood pressure (Hypertension) ? Yes No

Do you have any kind of heart condition ? Yes No

If Yes, what: ___________________________________

Have you ever had a PE, DVT or blood clots ? Yes No

Have you had Gastric banding surgery ? Yes No

Any other Surgical weight loss procedure ? Yes No

Have you had any other **operations**? Please list and add the year. ___________________________________

____

____

____

Please list any other medical conditions you have:

____

____

____

____

____

____

Do you smoke ? Yes No

If yes, how many per day: ____________________

Do you drink alcohol ? Yes No

If yes, how much per week: ____________________

Do you have, or have you ever suffered from:

VRE Vancomycin Resistant Enterococci Yes No

MRSA Methicillin Resistant Staphylococcus Aureus Yes No

Any other wound infections ? Yes No

Hepatitis B or C ? Yes No

If yes, is it still active ? Yes No

Do you take, or have you recently taken, blood thinning medications. eg: aspirin, Astrix, Cartia, warfarin, clopidogrel, Plavix, or anti-inflammatory medication ? Yes No

Name of medication(s): ______________________________

Date last taken: _____ / _____ / __________

Are you taking any non-prescription or natural complementary medications, or illicit drugs ? Yes No

If so, what : ___________________________________

____

____

List all medications that you are currently taking:

MEDICATION	STRENGTH

How did you hear about us ?

- ☐ GP recommendation
- ☐ Google / internet search
- ☐ Recommendation by friend
- ☐ Healthshare website
- ☐ Rate MD website
- ☐ Other: _______________