



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: _____

Usual 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 your 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: ____/____/____

