KURMIS ORTHOPAEDICS

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 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

———————————————————————

Have you had **x-rays or other imaging** of the body part we are seeing you about in the **last 12 months**: Yes No

If yes, at which Radiology company were these taken ?

☐ Dr. Jones & Partners ☐ Benson Radiology

☐ Radiology SA ☐ Fowler Simmons Radiology

☐ other (where): _____

———————————————————————

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: _____

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

If yes, please list: _____

_____

_____

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 blood thinning medications. eg: aspirin, Plavix, warfarin, clopidogrel, or anti-inflammatories ? Yes No

If yes, name of medication(s): _____

_____

———————————————————————

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 ☐ Physiotherapist

☐ Recommendation by friend ☐ Healthshare website

☐ Rate MD website ☐ Other: _____