KURMIS ORTHOPAEDICS

Specialising in:

- **Primary, Complex Primary and Revision Knee & Hip Replacement Surgery**
- **Technology- & Robot-assisted surgery**
- **General Adult Orthopaedics**

PATIENT INFORMATION (please print clearly and complete all sections)

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

Surname: _____

Given name(s): _____

Date of Birth: _____ /_____ /_____

Home address: _____

_____

_____Post Code: _____

Phone no.: Home: _____

Mobile: _____

E-mail: _____

Do you have a **smartphone** ? Yes No

If yes: ☐ iPhone ☐ Android

Next of Kin: _____

Relationship: _____

Phone no.: Home: _____

Mobile: _____

Usual family Doctor: **Dr.** _____

Address: _____

_____

_____Post Code: _____

Referring Doctor: (if different from above)

Dr. _____

Address: _____

_____Post Code: _____

Provider number: _____

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 active Private Hospital Insurance ? Yes No

Private Health Fund name: _____

Membership Number: _____

Are you covered by an approved **WorkCover** (eg. Return to Work SA) claim ? Yes No

If so, approved claim number: _____

Case manager: _____

Do you have a Concession Card ? Yes No

Pension Card number: _____

Expiry Date: _____ /_____ /_____

Health Care Card number: _____

Expiry Date: _____ /_____ /_____

Veteran Affairs Card number:_____

Gold Card Yes No **White Card** Yes No

What condition does the white card cover ?

_____

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 (i.e. surgeon's gap) which is an extra cost that is not Medicare rebateable and is not covered by Private Hospital Insurance.

Your Declaration:

☑ I have read the above information and the available *Privacy Statement* and agree to the said terms and conditions.

☑ I provide my *enduring consent* for the benefit of any bulk-billed services to be assigned to the care provider.

☑ I accept full financial responsibility for any appointment, surgical or other costs associated with my care.

☑ I give my consent for the use of technology-enhanced healthcare including, but not limited to, artificial intelligence driven active listening and consultation transcription, digital operative planning / templating, and surgical robotics.

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

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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 ?

☐ Jones Radiology ☐ 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 + 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: _____

Have you ever had a **skin reaction** to:

Skin / wound glue ? Yes No

Adhesive wound dressings / tapes ? Yes No

Do you have a confirmed **metal allergy** ? Yes No

Do you have a confirmed **latex allergy** ? Yes No

Are you sensitive or **allergic** to any medicines, foods, anti-septics 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

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Do you take **blood thinning medications**. eg: *clopidogrel, aspirin, rivarioxaban, apixaban, warfarin* ? Yes No

If yes, name of medication(s): _____

_____

———————————————————————————

Are you taking any non-prescription or 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: _____