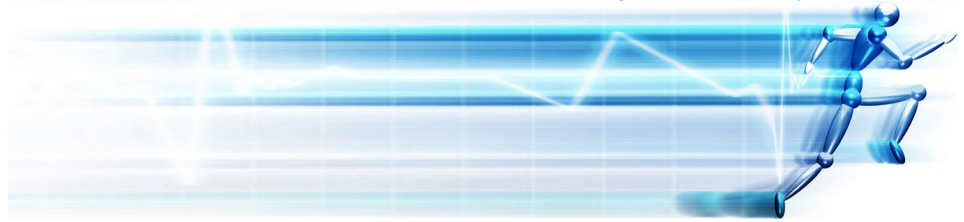


**Orthopaedic Surgeon**  
**Mr George Bousounis**  
 MBBS, FRACS, FAOrthA

**Hip and Knee Surgeon**  
[www.rapidrecoveryjoints.com.au](http://www.rapidrecoveryjoints.com.au)



## Rapid Recovery Joint Replacement Surgery

### Patient Registration Form

#### Patient Information

Title:  Mr  Mst  Mrs  Miss  Ms  Dr  Prof

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Address: \_\_\_\_\_

Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Person Responsible For Payment of Account:  Self  Parent  TAC  Workcover  Veteran's Affair  Other

• If parent or other, name of person: \_\_\_\_\_

• Relationship to patient: \_\_\_\_\_

#### Claim Details

Medicare Number: \_\_\_\_\_ ( ) no. left of name Exp Date: \_\_\_\_\_

Private Health Insurance:  YES  NO Health Fund Name: \_\_\_\_\_

Health Fund Membership Number: \_\_\_\_\_ Date Joined: \_\_\_\_\_

Usual GP Name: \_\_\_\_\_ GP Provider Number: \_\_\_\_\_

• Address and Tel: \_\_\_\_\_

Referring Doctor (if different from above): \_\_\_\_\_

• Address and Tel: \_\_\_\_\_

#### Concession Cards:

• Aged Pension or Health Care Card No: \_\_\_\_\_ Exp Date: \_\_\_\_\_

• Dept. Vet. Affairs Card No: \_\_\_\_\_  White  Gold Exp Date: \_\_\_\_\_

TAC Details (if applicable): Claim No: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

WorkCover (if applicable): Claim No: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

• Employer: \_\_\_\_\_

• Employer Address: \_\_\_\_\_

• Employer Phone: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Turn overleaf.

## Medical History

What is your current: Weight (kgs) \_\_\_\_\_ and Height (cm) \_\_\_\_\_

Have you suffered from or receive treatment for:

- |  |   |
|--|---|
| <input type="checkbox"/> Heart trouble (e.g. AML, angina, heart failure) | <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II |
| <input type="checkbox"/> Lung disease                                    | <input type="checkbox"/> High blood pressure  |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Blood clots (DVT/PE)   |
| <input type="checkbox"/> Kidney disease                                  | <input type="checkbox"/> Bleeding disorders   |
| <input type="checkbox"/> Stomach ulcers / Reflux                         | <input type="checkbox"/> Smoker   |
| <input type="checkbox"/> Blood disease                                   | <input type="checkbox"/> Viruses  |
| <input type="checkbox"/> Other: _____                                    |   |

Allergies:

- To medication: \_\_\_\_\_
- Latex / Tapes
- Other: \_\_\_\_\_

Are you taking any blood thinning medication:  YES  NO

- Warfarin  Aspirin  Plavix/Iscover (Clopidogrel)  Eliquis (Apixaban)  Xarelto (Rivaroxaban)
- Other: \_\_\_\_\_

## Health Records Act 2001 Collection Statement

Mr George Bousounis is collecting your health information to provide you with health services. Please read and sign to give approval for this information to be collected and stored. Your medical information may be used in the following way:

- To gain a history, diagnose disease and provide treatment where necessary.
- Administrative purposes in running this medical practice.
- Disclosure to other health care professionals involved in your health care. This includes treating doctors and specialists outside this medical practice, as well as pathology, radiology, Medicare and private health funds. This may occur through referral to other doctors or for medical tests and in the reports or results returned to us following the referrals.
- Health information may also be used for secondary purposes such as auditing surgical results, clinical research and teaching. Record keeping may also include x-rays, and clinical photographs and videos when required. The privacy of individuals is strictly maintained in these circumstances.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements and debt collecting agencies.

I consent to Mr George Bousounis collecting my health information.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Referral Source

How did you hear about Mr George Bousounis?

- Referred by Doctor,  Internet,  Personal recommendation,  Other: \_\_\_\_\_

## Notice About Fees

All consultations are payable at the time of service. The cost of consultation is above the Medicare schedule fee. This means you will not recover the full fee after claiming from Medicare. If you require further information about the payment of your consultation please feel free to speak to our friendly staff who will be happy to assist.