Jit Balakumar

MBBS FRACS(Orth)

Paediatric & Adult Orthopaedic Surgeon

Confidential Patient Information

PERSONAL DETAILS

☐ Mr ☐ Mrs ☐ Master ☐ Miss ☐ Ms ☐ Dr ☐ Prof ☐ Other **Date of Birth:** _____/_____/_____

Surname: _____ **Given Name:** _____

Address: _____

Suburb: _____ **Postcode:** _____

Email: _____

Occupation: _____

or School Year: _____ **or University Year and Course:** _____

Telephone Numbers:

Home: _____ Work: _____ Mobile: _____

Next of kin details (family member or friend / medical power of attorney)

Name: _____ Relationship to you: _____

Contact number: _____

Mother's Name: _____ **Father's Name:** _____

CLAIM DETAILS:

Medicare Number: _____ Ref No: _____ Exp Date: _____

Private Health Insurance: ☐ Yes ☐ No Fund Name: _____ Fund Number: _____

Concession Cards:

Aged or Disability Pension No: _____ Exp Date: _____

Dept. Veterans Affairs Card No: _____ ☐ White ☐ Gold Exp Date: _____

Health Care Card No: _____ Exp Date: _____

WorkCover (If applicable) Claim No: _____ Insurer: _____

TAC Details (If applicable): Date of Accident: _____ Claim Number: _____

Usual GP Name: _____ GP Provider Number: _____

Practice details: _____

PLEASE TURN OVERLEAF

Consulting at:

64 Chapman St, Nth Melbourne, Vic 3051 Ph: **9329 5525** Fax: 9329 4969 Provider No: 231079NF

Epworth Richmond, Richmond, Vic 3121 Ph: **9426 8810** Fax: 9427 7929 Pager: 9387 1000

Operating at: The Avenue, Epworth Richmond, The Royal Children's Hospital & The Austin

ABN: 55 467 783 345

Email: info@jitbalakumar.com.au

www.jitbalakumar.com.au

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MEDICAL QUESTIONNAIRE

Regular Medications (Name, Dose, Frequency):_____

_____

Have you had a DVT/ PE or Family History of PE/DVT? ☐ Yes ☐ No **Have you ever had Heart Disease?** ☐ Yes ☐ No

Do you suffer from Asthma? ☐ Yes ☐ No If Yes, how is your Asthma managed? _____

Have you had adverse reactions to anaesthetics or family history of adverse anaesthetic reactions? ☐ Yes ☐ No

If Female: - Is there any chance you are pregnant? ☐ Yes ☐ No
(We may require X-rays or surgery both of which can affect pregnancy)

Are you allergic to any medicines, tapes or latex: ☐ Yes ☐ No If yes, please specify: _____

_____

AUTHORISATION AND CONSENT TO PHOTOGRAPHY/VIDEO

I, _____ *hereby consent that photographs be taken of me by Mr Jit Balakumar.*

Mr Jit Balakumar at all times respects patients right to privacy and informed consent for procedures within the practice including photographic records. I understand that these photographs form an essential part of my medical record as well as my preoperative and postoperative assessment. I understand and consent to my photographs being used by Mr Jit Balakumar for medical research, teaching and or patient education purposes. I understand that I will not be identified by name in any such use of these photographs, however in some circumstances the photographs may portray features that shall make my identity recognisable.

I give permission for Mr Jit Balakumar or his staff to contact me by telephone and if necessary leave a message.

I have read all of the above and all my questions have been answered.

Signature: _____ **Date:** ___/___/_____

HEALTH RECORDS ACT 2001 COLLECTION STATEMENT

Mr Jit Balakumar is collecting your health information for providing you with health services. Please read and sign to give approval for this information to be collected and stored. Your medical information will be used exclusively for providing health care in the following way:

- *To gain a history, diagnose disease and provide treatment where necessary;*
- *Administrative purposes in running this Practice, which may also include confirmation of your appointment.*
- *Writing reports to your Doctor and other Doctors involved in the provision of healthcare, and the storing of reports provided to this Practice by other Medical Specialists; and*
- *Billing and collection purposes, including but not limited to compliance with Private Health Fund, Medicare and Health Insurance Commission requirements. You may gain access to your health information by writing to us. If you do not consent to providing us with your health information we may be unable to provide you with health services.*

I consent to Mr Jit Balakumar collecting my health information. **Signature:** _____ **Date:** ___/___/_____

REFERRAL SOURCE: How did you hear about Mr Jit Balakumar? Referred by Doctor ☐ GP or ☐ Specialist

☐ Website – www.jitbalakumar.com.au ☐ or Royal Australian College of Surgeons (RACS) website

☐ Google ☐ Yellow Pages ☐ White Pages ☐ Personal recommendation: _____

☐ Other: _____

ALL CONSULTATIONS ARE PAYABLE AT THE TIME OF SERVICE.

Unfortunately, we do not bulk bill, however for your convenience we can accept EFTPOS, Visa, MasterCard, cheque and cash.

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