Dr Vytauras Kuzinkovas

Advanced Surgicare

Patient Information

(Please Print)

Personal Details	
Surname:	First Name:
DOB:	Age:
Address:	
	P/Code:
Home Phone:	Mobile:
Work Phone:	Email:
	Can we use this email to contact you regarding your treatment?
	Yes: ☐ No: ☐
Occupation:	Religion:
Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Defacto ☐	
Children:	
Are you an Australian Resident: Yes ☐ No ☐	
Country of Birth:	If Australia, specify state:
Are you of Aboriginal/Torres Strait Islander (TSI) decent descent? No☐ Aboriginal☐ TSI☐ Both☐	

Other Contact (Spouse, Partner, Parent, Other Relative, Friend)		
Name:	Relationship:	
Address:		
	P/Code:	
Home Phone:	Mobile:	
Work Phone:	Email:	
Insurance		
Medicare:	Ref # :	Exp. Date:
Health Fund:	Membership # :	
Pension:	Exp. Date:	
Veteran Affairs #:	DVA Card Colour:	

GP Details	
Name:	
Address:	
	P/Code:
Phone:	Fax:
Email:	

Other Doctors / Specialists you see:		
Name:	Address:	Speciality:

Referral Details:
How did your hear about our Practice?:
Name of Referring Doctor:
Reason for Referral: