

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: <input type="checkbox"/> No: <input type="checkbox"/>	
Occupation:	Religion:
Marital Status: Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Defacto <input type="checkbox"/>	
Children:	
Are you an Australian Resident: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Country of Birth:	If Australia, specify state:
Are you of Aboriginal/Torres Strait Islander (TSI) decent descent? No <input type="checkbox"/> Aboriginal <input type="checkbox"/> TSI <input type="checkbox"/> Both <input type="checkbox"/>	

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 you hear about our Practice?:
Name of Referring Doctor:
Reason for Referral: