



Family Medical Practice
Aesthetic Laser and Vein Centre

Dr. Johann van der Merwe, MD
Dr. Helena Mentz, MD
Dr. Wessel Kriel, MD
Dr. Jeane Lombard, MD

PATIENT REGISTRATION

Last Name : ..... First Name : ..... Initials: .....

Preferred name : ..... Title : ..... Date of birth : [ ] [ ] - [ ] [ ] - [ ] [ ]
D D M M Y Y

Provincial health insurance number : [ ] [ ] [ ] [ ] [ ] - [ ] [ ] [ ] [ ] Province : .....

Home address: .....

Work address: .....

Telephone (Home): ..... Telephone (Work): .....ext .....

Name and address of a family member / friend we may contact if required:

Name : .....

Address: .....

Telephone: ..... (home) .....(work)

Names of other family members living with you, who may also register as patients (or) are registered with us:

Table with 3 columns: Name, Relationship, Date of birth. Rows 1-5.

I have received an information pamphlet explaining the office policies of this medical practice.

Date: .....

Signature of patient: .....