MonaLisa Dental Centre

2866 west 4th Avenue
Vancouver B.C. V6K1R2
778-379-7575

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? Yes ❑ No	If not, what is your legal name?	Preferred Name:	Birth date (dd/mm/yyyy): / /	Sex: ❑ M ❑ F

Family members seen here:	Email:	Phone no.: ( )

Street address:	City:	Province:	Postal Code:

INSURANCE INFORMATION

(Please fill your insurance information or give your insurance card to the receptionist.)

Insurance Carrier Name	Group/Policy/Plan/Contract No.	ID / Certificate No.

Healthcare Number:	Employer / Company Name:	Work Phone No.:	Name of Policy Holder/Birthdate

2nd Insurance Carrier name	Group/Policy/Plan/Contract No.	ID / Certificate No.	Name of Poilcy Holder/Birthdate

How did you hear about MonaLisa Dental Centre?

(We like to give credit to our patients for referring their friends and family, please specify how you heard of our office. Thank you.)

Online ❑	Walk In ❑	Family / Friend ❑	Name:	Advertisement ❑	Name:

DENTAL HISTORY

When was the last time you went to the dentists? Was a cleaning done? Where any X-rays taken?	
What was your previous dentist's name? (or clinic)	
Do you have any pain or concerns about your teeth?	
How often do you brush and floss?	
Are you nervous about having dental treatment?	
Do you clench or grind your teeth?	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone no.: ( )

CONSENT

The above information is true to the best of my knowledge. I understand that full payment is expected at the time of services, unless insurance applies. If insurance applies, I agree to pay the required deductible and estimated co-payments on date of service. I understand that I am financially responsible for any balance. I also authorize to Monalisa Dental Centre or insurance company to release any information required to process my claims.
I authorize Dr. Fouad Alethawy and his staff to perform diagnostic procedures and treatments that may be necessary for proper dental care.

Patient/Guardian signature *Date*