Goedzorg huisartsen
Laanzicht 3
8271 JZ IJsselmuiden
Tel: 038-2 038 999 Fax: 038-3327754

Formulier ingenomen door medewerker: _____

Registration form general practice

As a new patient you will be registered with general practitioner Dr. C.P van der Zee

Register by:_____

Main resident:

Surname: _____Male [ ] / Female [ ]

Firstname: _____

Street, number: _____

ZIP code: _____ Residence:_____

Phone number at home: _____ Mobile phone number:_____

BSN number: _____

Date of birth: _____ E-mail: _____

Name health insurance:_____ Policy number: _____

Sometimes it may be necessary to share medical information with other healthcare providers.
We ask you permission to share this necessary information via the LSP.
(For more information see the leaflet: Your medical data available through the LSP
(National Exchange Point)

[ ] Yes, I give my permission [ ] No, I don't give permission

Date: _____ Signature:_____

I hereby give permission to request the medical file from the previous general practitioner:

Former general practitioner:
Name : _____
Addres : _____
Place of recidence: _____
E-mail : _____

Informatie/ Verzoek voor vorige huisarts:
Willen jullie bij gebruik van Medicom binnen de regio Zwolle, de artsencode omzetten naar **HD**

Partner:

Firstname / Surname: _____Male [ ] / Female [ ]

Mobile phone number:_____

BSN number: _____

Date of birth: _____ E-mail:_____

Name health insurance:_____ Policy number: _____

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[ ] Yes, I give my permission [ ] No, I don't give permission

Other family members:

Firstname / Surname: _____Male [ ] / Female [ ]

Mobile phone number:_____

BSN number: _____

Date of birth: _____ E-mail: _____

Name health insurance:_____ Policy number: _____

Firstname / Surname: _____Male [ ] / Female [ ]

Mobile phone number:_____

BSN number: _____

Date of birth: _____ E-mail: _____

Name health insurance:_____ Policy number: _____

Other family members:

Firstname / Surname: _____Male [ ] / Female [ ]

Mobile phone number:_____

BSN number: _____

Date of birth: _____ E-mail: _____

Name health insurance:_____ Policy number: _____

Firstname / Surname: _____Male [ ] / Female [ ]

Mobile phone number:_____

BSN number: _____

Date of birth: _____ E-mail: _____

Name health insurance:_____ Policy number: _____

Firstname / Surname: _____Male [ ] / Female [ ]

Mobile phone number:_____

BSN number: _____

Date of birth: _____ E-mail: _____

Name health insurance:_____ Policy number: _____
