Code medewerker na inname formulier: _____

Registration form general practice

As a new patient you will be registered with general practitioner Dr. K.Strating

Register by:_____

Main resident: (Please complete in block letters)

Surname: _____Male [ ] / Female [ ]

Firstname: _____

Street, number: _____

ZIP code: _____ Residence:_____

Mobile phone number:_____

Country of origin:_____ Spoken language:_____

Need a translator: Yes/ No

BSN number: _____

Date of birth: _____ E-mail: _____

Name health insurance:_____ Policy number: _____

I want to be registered with pharmacy: _____*(Name and location pharmacy)*
You must inform your previous pharmacy of your move.

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.

[ ] 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 : _____

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Partner:

Firstname / Surname: _____Male [ ] / Female [ ]

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.

[ ] 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: _____

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

---

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

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Other family members:

Firstname / Surname: _____Male [ ] / Female [ ]

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.

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

---

Firstname / Surname: _____Male [ ] / Female [ ]

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.

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

---

Firstname / Surname: _____Male [ ] / Female [ ]

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.

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

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