

GP practices Conservatoriumlaan

Registration form new patients

Last name, initials: _____ First name: _____
Date of birth: _____ M / F* _____
Adres: _____
Zipcode: _____ Residence: _____
Telephone number: _____ Mobile number: _____
E-mail adress: _____
BSN number: _____
ID: _____ Passport / ID card* number.: _____

Choice of GP: _____ Wijffels/ Mees/ Hekking: _____

Insurance: _____ Policy nr.: _____
(New) pharmacy: _____
Previous GP: _____ Residence: _____

Medical history

- Have you ever had an allergy to medicines or otherwise?

- Are you being treated by a specialist? If so, in which hospital, name of specialist and for what purpose? Or do you have a chronic illness?

Do you use medicines: Yes / No*

Please request an overview of your medication from your pharmacy and take it with you during your first visit to the doctor.

Do you agree to inspect your medical file for the acting (general practitioner) doctor (in the absence of your own GP and / or visit to a GP post) and pharmacy? YES / NO*

For more information, see www.vzvz.nl

Date: _____

Signature: _____

Please leave the below open for practice assistant

Aangenomen en gecontroleerd door	
Datum	
Datum kennismaking	