REGISTRATION FORM

initials:

first name :

last name:

date of birth:

sex as registered in passport: M V X

optional

gender: man / woman / non binary

pronouns:

address:

postal code*:

city:

phone number:

e-mail address:

* if your postal code is different from 1011 or 1012, please provide a brief explanation of why you wish to register with our practice:

BSN:

health insurance:

relation number:

pharmacy:

previous gp:

I hereby grant permission for the activation of the National Exchange Point (LSP), so that other healthcare providers (such as the Huisartsenpost and pharmacies) may access my medical records in case of emergency care — yes no

I hereby grant permission to Huisartsenpraktijk Oudezijde to request my medical records from my previous general practitioner — yes no

signature: date: