Registration form general practice Huisartsenpraktijk Berent Avercamp

Main resident:

Surname: .................................................................................................... Male [ ] / Female [ ] Firstname: ………………………………Initials……..………. Date of birth: ...............................................

Street, number: ...........................................................................................................................

Postal code: ..................................... Town:.................................................................................

BSN number:…………….………………………………………… Occupation:………………………………………………

Home telephone number. ..........................…………………………………………………………………………….

Mobile telephone number. .........................................................................................................

E-mailaddress:…………………………………………………………………………………………………………………..…..

Name health insurance:...............................................................................................................

Policy number:....................................................Parmacy:..........................................................

General practitioner with whom I/we want to be registerd at:………………………………………………..

Registration Date: …....................................................................................................................

Signature......................................................................................................................................

Partner:

Surname: .................................................................................................... Male [ ] / Female [ ] Firstname: ……………………………Initials…………..………. Date of birth: ............................................

BSN number:…………….………………………………………….. Occupation:……………………………………………

Mobile telephone number. .........................................................................................................

E-mailaddress:…………………………………………………………………………………………………………………..…..

Name health insurance:...............................................................................................................

Policy number:.............................................................................................................................

Registration Date: …...........................................Parmacy:...........................................................

Signature......................................................................................................................................

**Are your children over 16 years old? Please submit a separate registration form.**

Children / Other family members

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Name | Date of birth | M/F | Health insurance | Policy number | BSN number:  |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |

**When submitting this registration form, please include a copy of your ID and LSP form**

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

If your previous general practitioner is also located in Kampen, an introductory meeting is recommended first.

Name previous general practitioner: ..........................................................................................

Town : …………………………………………………………………………………..……………………………………………….

*NB:* Registered patients must also inform their previous general practitioner of changing to Huisartsenpraktijk Berent Avercamp.

Particulars regarding your health and/or that of your family members that the doctor must be aware of.

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EWM Snel

M Reitsma

SO Driessen

R van der Hoef

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*8261 EE Kampen*

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