**Registration form for new patients**

(\* circle what applies)

Surname: ............................................................................................................

Maiden name: ............................................................................................................

Initials/first name: ............................................................................................................

Date of birth/place: ............................................................................................................

Gender \*: Male/ Female

Full address: ............................................................................................................

Telephone number(s): ............................................................................................................

Email address: ............................................................................................................

Health Insurance: ............................................................................................................

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

Citizen service number: ............................................................................................................

(Please attach a copy of your insurance card)

Pharmacy \*: Zonegge / Anjer

Are you familiar with hypersensitivities/ allergies? (e.g. medication, latex etc.) :

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Do you have chronic diseases? (e.g. diabetes or high blood pressure, lung diseases):

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Did you receive annual check-ups and/or lab calls from your previous GP? If so, which one?

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Details of previous GP: ........................................................................................................

Permission to request data from your previous GP **YES / NO** \*

Permission for registration LSP Opt-in (see www.volgjezorg.nl) **YES / NO** \*

(If a minor, the form must be signed by both authoritative parents/guardians.)

Signature: Date:

**Please request your previous GP to send your medical file to us via healthcare email.**