

**Registration General Practice Palembang  
Palembangstraat 52, 1094 TK Amsterdam  
Telephone 020-665.54.55**

Name: \_\_\_\_\_ First name: \_\_\_\_\_  
Initials: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Male/Female/X \_\_\_\_\_  
Address: \_\_\_\_\_ Postal Code and Residence: \_\_\_\_\_  
Marital status: married/unmarried/living together/divorced/widow(er) \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
Health Insurer: \_\_\_\_\_ Insurance number: \_\_\_\_\_  
BSN: \_\_\_\_\_ New Pharmacy: \_\_\_\_\_

Name and telephone number contact in case of emergency: \_\_\_\_\_

Reason of registration: \_\_\_\_\_

Have you been a patient with us before? Yes/No \_\_\_\_\_

Do you give us permission to share your medical information with other healthcare providers (General practitioner's out-of-hours service/emergency department) if this is necessary for your treatment? Yes/No \_\_\_\_\_

Name previous doctor: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_ Place: \_\_\_\_\_

**By signing this form you give us permission to deregister from your previous doctor and to request your medical file.**

Date of registration: \_\_\_\_\_ Signature: \_\_\_\_\_

**In case of minor children:**

Name of parent/guardian 1: \_\_\_\_\_ Name of parent/guardian 2: \_\_\_\_\_  
Signature of parent/guardian 1: \_\_\_\_\_ Signature of parent/guardian 2: \_\_\_\_\_

**NB! You are not registered until you have received a confirmation email from us!**

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To be completed by doctor's assistant:

<input type="checkbox"/> legitimatie gecontroleerd	<input type="checkbox"/> ingevoerd in HealthConnected
<input type="checkbox"/> praktijkinformatie meegegeven	<input type="checkbox"/> aangemeld bij ION
<input type="checkbox"/> inschrijfformulier gescand	<input type="checkbox"/> dossier opgevraagd per mail op:
<input type="checkbox"/> kennismakingsgesprek gepland	<input type="checkbox"/> bevestigingsmail verzonden