# 

# Registration form

# Gezondheidscentrum Duizendblad Kamillelaan 1G

# 1187 ER Amstelveen

**o** Praktijk van Zuylen

020-3451171

|  |  |
| --- | --- |
| Surname |  |
| Initials |  |
| Name |  |
| Date of birth |  |
| Adress |  |
| Zip code + city |  |
| 06 number |  |
| Email |  |
| Burger Service Number (BSN) |  |
| Name health insurance + number |  |
| Pharmacy of your own choice |  |
| Name previous GP + phonenumber |  |
| Date | Signature |
| By singing this form you consent to the request your medical file at your previous GP | |

**Please enclose a copy of a valid identity document and health insurance card. These copies will be destroyed after we completed your registration.**

You may also send the registration form together with the copy of the identity and health insurance card **huisartsvanzuylen@huisartsenduizendblad.nl**

**Z.O.Z**

**Permission form**

**Your medical data available through the LSP**

**YES NO**

I **do** authorize the below-mentioned healthcare provider making my data available through the LSP. I have read all the information contained in the ‘Your medical data available through the LSP (National Exchange Point)’ leaflet.

**GP or pharmacy details**

I **do not** authorize the below-mentioned healthcare provider making my data available through the LSP. I have read all the information contained in the ‘Your medical data available through the LSP (National Exchange Point)’ leaflet.

**Which healthcare provider does this form concern?**

**my GP**

**my pharmacy**

**Name GP:** ..............................................................................................................................................................................................................................................................................................................

**Address:** ..............................................................................................................................................................................................................................................................................................................................................................................

**Postcode and town:** ...........................................................................................................................................................................................................................................................................................................................................

Should you wish to grant permission to another healthcare provider as well? Please complete a new permission form.

**My details** do not forget to sign the form

**Family name:** ...............................................................................................................................................

**Initials:** ......................................................................................................

**M**

**F**

**Address:** ..............................................................................................................................................................................................................................................................................................................................................................................

**Postcode and town:** ...........................................................................................................................................................................................................................................................................................................................................

**Date of birth:** ...............................................................................................................................................................................................................................................................................................................................................................

**Do you wish to give permission for your children?**

* For children up to age 12: as a parent or guardian, you have to give your permission. Please use this form.
* For children aged 12 to 16 who wish to give their permission: both the parent or guardian and the child need to sign the form.
* Children aged 16 and over need to give permission themselves and complete the form themselves.

**Details of my children**

Complete the below details of the children with respect to whom you wish to give permission. Do not forget to provide your own signature. Do you have more than two children? Please complete a new permission form.

**Personal and family name:** ...............................................................................................................................................................................................................................................

**M**

**F**

**Date of birth:** ........................................................... **Child’s signature:** .................................................................................................................................................................

**YES**

**NO**

**Personal and family name:** ...............................................................................................................................................................................................................................................

**M**

**F**

**Date of birth:** ........................................................... **Child’s signature:** .................................................................................................................................................................

**YES**

**NO**

Do you have more than two children? Please complete a new permission form.

**Submit this form to the GP of pharmacy your permission concerns.**