# REGISTRATION FORM

| | | |
|---|---|---|
| Sur Name | M/F | |
| Initials | | |
| First name | | |
| Date of birth | | |
| Address | | |
| Zip code | | |
| | Rotterdam | |
| Telephone number | 010 - | |
| Mobile phone | 06- | |
| E-mail | | |
| Pharmacy | | |
| Insurance company | | *uzovi* |
| Insurance number | | |
| ID card or passport | | |
| ID number | | |
| Social Security Number (BSN) | | |

Have you been a patiënt of dr Poelstra before? yes/no

Are there any familymembers on the same address already a patiënt of dr Poelstra? yes/no

Hereby I declare that

F. Poelstra, family doctor
Oudedijk 299a
3061 AL Rotterdam
Tel: 010-4520330

is my family doctor and that I give him permission to request for my medical file from my previous family doctor.

| | | |
|---|---|---|
| Name previous family doctor: | | |
| Address: | | |
| Zip code: | City: | Country: |

Rotterdam Date:

Signature:

*ION AANGEMELD*

*EINDDATUM*