UGC Heyendael
Universitair gezondheidscentrum

REGISTRATION FORM

O TransHis	O Vecozo
O context formulier	O scan
O Fax	O pin code app

Please use this form to register in our practice and bring a valid ID.

Surname: ______________________________________

Maiden name (if applicable): ________________________

Given name: ____________________________________

Initials: _______________________________________

Date of birth: ___________________________________

Gender: male/female/other, ________________________

Street and number: _______________________________

Postal code: ____________________________________

City: ____

Telephone: _____________________________________

2nd telephone number: ____________________________

E-mail: ____

Citizen Service Number (BSN): _____________________

Health insurer: __________________________________

Insurance number: ________________________________

New pharmacy: __________________________________

Previous GP: ____________________________________

Address previous GP: _____________________________

I hereby consent to the exchange of my patient details with the hospital, pharmacy and the out-of-hours primary care.
I hereby consent to register and to transfer my patient file to the general practice

Date ______________________ Signature __________________________