	<b>Registration form GP practice de Greev'</b>	
	T. van Ede C.E. Hulshoff-Friedrich M. Mennink	P.P.E. Sival I.C.L. Verhoeven

Dear reader,

Please fill in this form and submitting it to our practice, then we can register you at our general practice. After registration you will receive an e-mail or possibly a letter which GP you has been assigned to.

You can register any family members directly by filling in the second page of this document.


In order to finalize your registration, we must check your identity on the basis of a valid ID-document. You can choose to send a copy of your ID-document by e-mail to us. If this does not work, you can show your identity document at the counter.

\* Required

Registration form			
Initial(s)*		First name*	Male / Female / X
Surname*		Date of birth*	
Address*		House number*	
City*		Zip code*	
Mobile phone number*		Telephone number	
Telephone number 1° contact person		Relationship 1° contact person	
E-mail address*			
Name insurance company*			
Insurance number*			
Citizen service number*			
ID-type*	<input type="checkbox"/> Passport <input type="checkbox"/> Driver's license <input type="checkbox"/> ID-card <input type="checkbox"/> Other, ....		
ID document number*			
Nationality ID*			
Expiration date *			
Pharmacy*			
Allergies			
Name previous GP*			
Address previous GP*		House number*	
City*		Zip code*	
Reason for registration	<input type="checkbox"/> Birth <input type="checkbox"/> Relocation from abroad <input type="checkbox"/> Other		
Have you previously been registered in practice?	<input type="checkbox"/> Yes, unit _____ (year) <input type="checkbox"/> No		
Sometimes it may be necessary <b>to share medical information</b> with other healthcare providers. We ask you permission to share this necessary information <b>through the LSP</b> . For more information see: <a href="http://www.VZVZ.nl">www.VZVZ.nl</a> . You can always see who has accessed your data and keep control of who is allowed to see your medical information. Check it on <a href="http://www.volgiezorg.nl">www.volgiezorg.nl</a>		<input type="checkbox"/> I give my permission <input type="checkbox"/> I don't give my permission	
<b>I hereby declare that I am aware of the terms and conditions and information related to the LSP.*</b>		(tick*)	<input type="checkbox"/>
Do you give us permission to request your medical file from your previous GP?*		<input type="checkbox"/> Yes, I give my permission <input type="checkbox"/> No, I don't give my permission	
<b>Signature*:</b>			<b>Date of registration*:</b>

Administration Huisartsenpraktijk de Greev', Grevelingenstraat 10, 3522 PR Utrecht  
mw. Y. Roestenburg (present Monday, Tuesday, Thursday from 8.00-16.30 o'clock)  
[y.roestenburg@degreev.nl](mailto:y.roestenburg@degreev.nl) / 030-2881507 / [www.huisartsendegreev.nl](http://www.huisartsendegreev.nl)

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**Registration form family members**

With this form I ..... (initial(s) + surname), requests, date of birth ..... born at ..... to register the family members with the general practioners de Greev' at Utrecht.

**Family members data:**

\* Required

	Family member 1	Family member 2	Family member 3	Family member 4	Family member 5
<b>Surname*</b>					
<b>Initial(s) and first name*</b>					
<b>Male/Female/X*</b>	M / F / X	M / F / X	M / F / X	M / F / X	M / F / X
<b>Date of birth*</b>					
<b>Citizen service number*</b>					
<b>ID-type*</b>	0 Passport 0 Driver's license 0 ID-card 0 Other, ...	0 Passport 0 Driver's license 0 ID-card 0 Other, ...	0 Passport 0 Driver's license 0 ID-card 0 Other, ...	0 Passport 0 Driver's license 0 ID-card 0 Other, ...	0 Passport 0 Driver's license 0 ID-card 0 Other, ...
<b>ID-number*</b>					
<b>Nationality ID*</b>					
<b>Expiration date *</b>					
<b>Name insurance company *</b>					
<b>Insurance number *</b>					
<b>Telephone number*</b>					
<b>Telephone number first contact person</b>					
<b>Relationship 1<sup>e</sup> contact person</b>					
<b>E-mail address</b>					
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<b>Permission LSP</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>I hereby declare that I am aware of the terms and conditions and information related to the LSP.*</b>					
<i>tick*</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional comments:

To make an appointment, you can consult the patient portal or contact the GP: 030 – 288 15 07, choice 3

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