

Dear Sir / Madam,

**Welcome to our practice!** You can register with us as a patient if you live in one of the following zip code areas: 1509, 1508, 1541, 1544, and 1456 (Noorderweg until house no. 116). We ask you to complete the registration form, print it and hand it in personally at the practice. Your ID will be checked on site; we kindly ask you to bring it with you. A copy of your ID and insurance card is not required.

Please note: you are only definitively registered as a patient with us once we have checked the registration form.

A separate registration form must be completed for each family member.
For children up to 12 years old, both parents or guardian(s) must sign.
For children aged 12-16, both parents or guardians and the child must sign.
Children aged 16 and over must complete and sign their own form.

We request that you inform your previous general practitioner, pharmacy and treating specialist(s) of your registration with the practice.

When a baby is born, a new medical file must be created for your child. It helps us if you also provide all registration details for your newborn.

The practice is run by dr. S.A. van Gellekom and dr. S. Aydin. We also have dr. M. Vos working with us. You register with the practice and not with a specific doctor.

An introductory meeting is desirable, especially if you have an extensive medical history.

We wish you a warm welcome to the practice!

Yours sincerely,

Mrs. S.A. van Gellekom, general practitioner
Mrs. S. Aydin, general practitioner
Mrs. M. Vos, general practitioner

**Registration form General Practice 't Kalf**

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| --- | --- |
| Surname:  |  |
| First name:  |  |
| Gender:  |  |
| Date of birth: |  |
| Place of birth:  |  |
| BSN number: |  |
| Street name and house number: |  |
| Zip code and city:  |  |
| Telephone number: |  |
| E-mail:  |  |
| Insurance + policy number:  |  |
| Document number ID card / driver’s license / passport:  |  |
| Pharmacy:  |  |
| Emergency contact:(name and telephone number) |  |
| Details of previous general practitioner:(name, address and telephone number) |  |
| OPT-IN agreement YES/NO:(National switching point, share data with hospitals and/or pharmacies in case of emergency)  |  |

Date: Signature:
 *By means of this registration, I authorize General practice 't Kalf to request my medical file from my previous general practitioner.*