**Registration form**

*Please show your health insurance card and identity card when you register*

Family Name: ………………………………………………………… Initials: ………………

First name: ……………………………………………………….. Male / Female

Address: ……………………………………………………………….. Zip-code / Residence: ……………………………

Date of birth: \_ \_ / \_ \_ / \_ \_ \_ \_ Birthplace : …………………………………………

Burger Service number (BSN): …………………………………………………………………………………………………………….

Profession: ……………………………………………………… Country:…………………………………………………..

Home phone: ………………………………………………… Mobile number: ……………………………………………………….

Email address: ………………………………………………………………………………………………………………………………………..  
  
Pharmacy: ………………………………………………………..

Insurance company : ………………………………….UZOVI nummer: ……….. Polisnummer: ……………………………

Passport / ID-card / Drivers license number: …………………………………………………………………………………

Last general practitioner : ………………………………………………in ……………………………………………………………

Reason of departure: …………………………………………………………………………………………………………………………….

**------I give / do not give permission that my medical files will be---------------**

**exchanged via the LSP (see explanation letter on our website)---------**

Are you:

□ single

□ living together with ……………………………………………………..date of birth:……………………………………….

□ married to …………………………………………………………………………………………………………………………………….

□ other, namely ……………………………………………………………………………………………………………………………..

Date: \_ \_ / \_ \_ / \_ \_ \_ \_ Signature: ………………………………………………………

**(By signing this form you agree to transfer your medical file)**