Patient Information

Name:

Nationality:

CPR nr./D.O.B. (dd-mm-yyyy):

Contact phone number (include country code):

Contact e-mail address:

Country of residence:

Address:

Zip code:

Travel insurance company information:

(*If several: Choose primary health travel insurance provider)

Travel insurance company contact phone number:

Travel insurance company policy number:

Description of insurance coverage and max. limit:

***Provide a picture/copy of passport and insurance card**

Patient information form completed by:

Please send the completed form to turist@peqqik.gl