# 

# REGISTRATION FORM

## Personal information

|  |  |
| --- | --- |
| Family name: |  |
| Initials: |  |
| First name: |  |
| Date of birth: |  |
| Gender: | M / F / Other |
| Birth place |  |
| Tax Number (BSN) |  |
| Identity control performed with valid ID | Yes / No |

**Address**

|  |  |
| --- | --- |
| Address: |  |
| Phone number: |  |
| Mobile phone number: |  |
| Email address: |  |
| Occupation |  |

**Living arrangement:**

* Solo
* Together (name and date of birth of partner)
* Married
* One parent household
* Family

In case you have children we assume you share custody with your partner and both have knowledge of any visit to our practice and are in agreement about their treatment.

**Insurance information and tax number (BSN)**

|  |  |
| --- | --- |
| Name insurance provider: |  |
| Insurance policy number: |  |
| ID number: |  |

**Information previous GP**

|  |  |
| --- | --- |
| Name: |  |
| Street and house number: |  |
| City |  |
| Phone number |  |
| Name of emergency contact |  |
| Phone number of emergency contact |  |

**Which will be your pharmacy in Aalsmeer?**

* Pharmacy Groen
* Pharmacy van de Mooren
* Other ……………………………………………………………………..

**Permission to request and provide medical information**

* I hereby give permission to request my medical information from my previous general practice.

Date: Signature:

Do you want to sign up for ‘’mijngezondheidnet’’? This will give you online access to your medical file. For more information: www.mijngezondheid.net

* Yes
* No

**Medical information**

### Do you have any known intolerances or allergies to medication or excipients?

**(*e.g. antibiotics*)**

* no
* yes (fill in the relevant information)

*Medication and/or excipient side effect*

|  |  |
| --- | --- |
|  |  |
|  |  |

### Do you use any medication?

* no
* yes (fill in the medication)

***Name medication Dosage (mg) Amount per day or week***

|  |  |  |
| --- | --- | --- |
|  |  |  |
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|  |  |  |
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**Do you use self care products / alternative medicine / food supplements?** E.g. products you purchase from the pharmacy or drugstore?

* no
* yes (fill in which products you use)

|  |
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|  |

### Have you or your family members been diagnosed with any of the following diseases?

|  |  |  |
| --- | --- | --- |
|  | **Yourself** | **Family members** |
| Diabetes | * no ○ yes | * no ○ yes |
| Cardiovasculair disease | * no ○ yes | * no ○ yes |
| * high blood pressure | * no ○ yes | * no ○ yes |
| * high cholesterol | * no ○ yes | * no ○ yes |
| * stroke (CVA or TIA) | * no ○ yes | * no ○ yes |
| * heart problems | * no ○ yes | * no ○ yes |
| * vascular problems (claudication) | * no ○ yes | * no ○ yes |
| Kidney disease | * no ○ yes | * no ○ yes |
| Asthma or COPD | * no ○ yes | * no ○ yes |
| Eczema, hayfever, allergies | * no ○ yes | * no ○ yes |
| Gastro-intestinal disease | * no ○ yes | * no ○ yes |
| Colon cancer | * no ○ yes | * no ○ yes |
| Breast cancer | * no ○ yes | * no ○ yes |
| Other variants of cancer | * no ○ yes | * no ○ yes |
| Epilepsy | * no ○ yes | * no ○ yes |
| Other diseases of importance | * no ○ yes | * no ○ yes |

**Are there any known genetic diseases / disorders in your family?**

* + no
  + yes (fill in the relevant information)

*Name of genetic disease/disorder*

|  |
| --- |
|  |
|  |
|  |

### Do you receive the influenza vaccin?

* no
* yes (fill in the relevant information)

*Why?*

|  |
| --- |
|  |

### Are you under treatment by a medical specialist?

* no
* yes (fill in the relevant information)

*Name of specialist Name of hospital*

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

### Have you ever had surgery?

* no
* yes (fill in the relevant information)

*What kind of surgery? When?*

|  |  |
| --- | --- |
|  |  |
|  |  |

### Have you ever been in a serious accident?

* no
* yes (fill in the relevant information)

*When was the accident ? What kind of accident? Any lasting consequences?*

|  |  |  |
| --- | --- | --- |
|  |  |  |

### Are there any subjects the doctor should know about?

* no
* yes (fill in the relevant information)

|  |
| --- |
|  |

**Lifestyle**

### Do you smoke?

* no
* yes (fill in the relevant information)

*What do you smoke? How many per day/week?*

|  |  |
| --- | --- |
|  |  |

### Do you drink alcohol?

* no
* yes (fill in the relevant information)

*What do you drink? How many per day/week?*

|  |  |
| --- | --- |
|  |  |

### Do you use drugs?

* no
* yes (fill in the relevant information)

*Which drugs do you use? How many per day/week?*

|  |  |
| --- | --- |
|  |  |

**Do you have a living will?**

* no
* yes

*The following is to be filled in by the GP/assistants:*

|  |  |  |
| --- | --- | --- |
| **Checks door de praktijk** | **Datum** | **Paraaf** |
| Dossier ingevoerd in HIS |  |  |
| Medicatie, allergieën en contra  indicaties opgenomen in medicatiedossier |  |  |
| COV |  |  |
| ION |  |  |
| Verificatie door huisarts |  |  |
| Toestemming LSP verwerkt |  |  |
| Huisarts heeft dossier gelezen |  |  |
| Ruiter arts aangemaakt |  |  |

**Please deliver the completed form and a copy of your ID and insurance card to our practice.**

**When your medical file from your previous GP has transferred you can get in contact with us to arrange a meeting with your new GP.**

**Permission form**

**Your medical data available through the LSP.**

|  |  |
| --- | --- |
| **Yes** | **No** |
| I do authorize the below-mentioned healthcare provider making my data available through the LSP. I have read all the information contained in the ‘Your medical data available through the LSP (National Exchange Point)’ leaflet. | I do not authorize the below-mentioned healthcare provider making my data available through the LSP. I have read all the information contained in the ‘Your medical data available through the LSP (National Exchange Point)’ leaflet. |

# Information GP

|  |  |
| --- | --- |
| **Which healthcare provider is given permission?**  **Name: Huisartsenpraktijk Westeinder Address: 1e JC Mensinglaan 27A Zip code / City: 1431 RV Aalsmeer** | ** My GP** |

**Personal Information don’t forget your signature**

|  |  |  |  |
| --- | --- | --- | --- |
| **Family name:** | **Initials:** | ** M** | ** F** |
| **Address:** |  |  |  |
| **Zip code / City:** |  |  |  |
| **Date of birth:** | **Signature:** |  |  |
|  | **Date:** |  |  |

# Do you want to give permission on behalf of your children?

* For children up to 12 years old: you can give permission as parent or guardian using this form.
* For children 12 to 16 years old: both the parent/guardian and child need to sign this form.
* Children 16 years and older need to give permission using their own form.

# Information children

Fill in the information about the children on whose behalf you want to give permission. **Don’t forget your own signature as well.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Family name:** | **Initials:** | ** M** | ** F** |
| **Date of birth:** | **Signature:** | ** YES** | ** NO** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Family name:** | **Initials:** | ** M** | ** F** |
| **Date of birth:** | **Signature:** | ** YES** | ** NO** |

### Do you have more than two children? Please ask for an additional permission form.

**Signature**

**Parent or guardian:**

**Date:**