Registration form

To ensure succesful registration, we ask you to do the following:
- Completely fill out the form and hand it in at the doctor's practise. Make sure you bring your ID with you.
- Inform your previous doctor's practise that you are leaving.

By filling out this form you are registering at our doctor's practise.
If you are filling out this form for a child under the age of 16 years and you share custody, permission from the other parent or guardian is required.
A child/adolescent of 16 years and over is required to sign their own form.

Personal information

Family name:			
First and middle initials:			
(First) name:			
Date of birth:		Sex:	
In case of a child under 16 years: do you share custody with another parent/guardian? If yes, does the other parent/ guardian give permission for registration?			
The doctor's office will verify identification with a valid ID			

Address information

Street:			
Postal code:		City:	
Phone (house):			
Phone (mobile):			
E-mail address:			

Health insurance information and BSN-number

Insurance company:	
Policy number:	
BurgerServiceNummer	

Previous doctor's practise

Name practise:	
Address:	

Previous pharmacy

Name pharmacy:	
Address:	

Consent to request and share information

o I hereby grant consent to request my medical file from my previous doctor and pharmacy	

Date		Signature	

New pharmacy

Name pharmacy:	
Address:	

Medical information

Do you have any allergies or are you intolerant of any medications or additives? Have you ever experienced side effects from medications? Do you have any other allergies or intolerances?

yes (fill in the information down below)

Medication or additive allergy/intolerance	*Side effect*	*Other allergy/intolerance*

Do you use medication?

yes (fill in the information down below)

Medication name	*Dosage in mg*	*Usage per day or per week*

Do you use any over the counter medication that you bought at the pharmacy or drug store? Do you use any other form of medication such as alternative medicines or dietary supplements?

yes (fill in the information down below)

Do any of the following diseases run in your family?

	Yourself	*Family*
Diabetes		
Heart/vascular disease		
high blood pressure		
high cholesterol		
stroke		
heart problems		
vascular impairment (e.g. claudication)		
Kidney disease		
Asthma or COPD		
Eczema, hay fever, allergy		
Gastrointestinal disease		
Intestinal/colon cancer		
Breast cancer		
Other forms of cancer		
Epilepsy		

Other diseases of importance

Do any genetic diseases run in your family?

yes (fill in the information down below)

Name genetic disease

Which vaccinations have you had in the past?

Childhood vaccines		
Travel vaccines		
	If yes, which vaccines:	
Extra vaccines (e.g. hepatitis B)		
	If yes, which vaccines:	
Influenza vaccine (flu shot)		

Are you under treatment of a medical

Name specialist/department	*Name hospital*

Have you ever had surgery?

What kind of surgery?	*When was the surgery?*

Have you ever been in an accident?

When?	*What kind of?*	*Is there permanent damage?*

Is there anything else about you that your doctor needs to know?

Lifestyle

Weight	
Height	
Do you smoke?	

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

Do you use alcohol?	

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

Do you use drugs?	

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

This form has been truthfully and accurately

Date	*Name*	*Signature*

In case of registration for children between 12 en 16 years old, the child itself and at least 1 parent sign the form.

Consent form

Grant access to your medical file via the LSP

☐ **JA**

I do give persmission to the following health care professionals to provide access to my medical information via the LSP. I have read all the information in the information folder 'Jouw medische gegevens beschikbaar via het Landelijk Schakelpunt (LSP)'.

☐ **NEE**

I do not give persmission to the following health care professionals to provide access to my medical information via the LSP. I have read all the information in the information folder 'Jouw medische gegevens beschikbaar via het Landelijk Schakelpunt (LSP)'.

To which health care professional do you give permission?	
Name:	
Address:	
Postal code and city:	

Personal information

Family name:			
Initials:			
First name:			
Date of birth:		Sex:	
Signature:			
Date:			

Parental consent for acces to medical files

- *Use this form for parental consent for children 12 years old and under.*
- *Use this form for children between 12 and 16 years who wish to give consent: both the parent/guardian and the child need to sign.*
- *A different form is needed for children 16 years and older to give consent to access their files.*

My children's personal information

Fill in the information below of the children for whom you wish to give consent. Do not forget to sign the form.

Family name:			
Initials:			
Date of birth:		Sex:	
Signature:			

Family name:			
Initials:			
Date of birth:		Sex:	
Signature:			

Do you have more than two childeren? Please ask for an extra consent form.

Signature:	
Date of birth:	

Checks to be performed by the doctor's practise:	*Datum*	*Handtekening*
Dossier ingevoerd in HIS		
patiënt ingevoerd als: passant / vaste patiënt		
Actueel Medicatie Overzicht opgevraagd bij vorige apotheek		
Acuteel medicatie overzicht vorige apotheek ingevoerd in medicatiedossier denk ook aan de allergieen en contra indicaties		
Kennismakingsgesprek gepland HA: ja / nee / n.v.t.		
Ruiters toegevoegd dossier: ja / nee / n.v.t.		
COV		
ION		
Verificatie door huisarts		
Toestemming LSP verwerkt		