Code Arts	**ION**

Huisartsenpraktijk
BLANKENBURG
Blankenburg 3
3181 BC Rozenburg
Tel. (0181) 820 920

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:	M / F
Child's age < 12 yr: both parents/guardians sign for registration and exchange of medical information Child's age 12-16 yr: both parents/guardians, as well as the child, sign for registration and exchange of medical information Child's age > 16 yr:			Yes / No Yes / No Yes / No	

Date:…… Name 1st parent/guardian:…….... Signature: ……

Date:…… Name 2nd parent/guardian:…….....Signature: ……

Date:…… Name child:…….....Signature: ……

Praktijkmedewerker: voer Identiteitscontrole uit aan de hand van geldig ID

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Address information

Street + nr		
Postal code:		Plaats:
Phone (house):		
Phone (mobile):		
E-mail address:		
First contact (optional):		
More persons living on this address?	Yes / No Name and date of birth:	

Health insurance information and BSN-number

Insurance company:	
Policy number:	
BurgerServiceNummer:	

Previous doctor's practise

Name practice:	
Address:	

Previous pharmacy

Name pharmacy:	
Address:	

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New pharmacy

Name:	
Address:	

Consent to request and share information

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

Date: Signature:

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?
○ no
○ yes (fill in the information down below)

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

Do you use medication?
○ no
○ yes (fill in the information down below)

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

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Are you under treatment of a medical specialist?
○ no
○ yes (fill in the information down below)

Name specialist/department	*Name hospital*

Have you ever had surgery?
○ no
○ yes (fill in the information down below)

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

This form has been truthfully and accurately filled in: YES / NO

Date: ……. *Name …….* *Signature* *……*

LSP

On the next page you will find a consent form for LSP. This means that when you visit the emergency GP center, the doctors there can read the most important/recent information in your file. In addition, your pharmacy cab request information from the hospital about your medication.

Zorg-online/e-health

See link below. Through this online health portal it is possible to make appointments, to repeat chronic medication or to e-mail your doctor. In addition you can read part of your medical file.

Link: https://huisartsenpraktijkblankenburg.uwzorgonline.nl/inloggen-en-registratie/app

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Consent form

Grant access to your medical file via the LSP

☐ **YES**

I **do** give permission 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)'.

☐ **NO**

I **do not** give permission 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)'.

Information about your doctor or pharmacy

To which health care professional do you give permission?	☐ **my doctor** ☐ **my pharmacy**
Name:	.....
Address:	.....
Postal code and city:	.....

Personal information please remember to sign this document

Family name:	.....	**First and middle initials::**	.....	☐ **M**	☐ **F**
Address:	.....				
Postal code en city:	.....				
Date of birth:	.....	**Signature:**	.....		
		Date:	.....		

Parental consent for access to medical files

- Child's age < 12 yr: both parents/guardians sign for consent to access to files
- Child's age 12-16 yr: both parents/guardians, as well as the child, sign for consent to access files
- A different form is needed for children 16 years and older to give consent to access their files.

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My children's personal information

Fill in the information below of the children for whom you wish to give consent.

Name: **Initials:** ☐ **M** ☐ **F**

Date of birth:

Name + signature parent/guardian:

Name + signature parent/guardian:

Name + signature child when 12-16yrs:

Name: **Initials:** ☐ **M** ☐ **F**

Date of birth:

Name + signature parent/guardian:

Name + signature parent/guardian:

Name + signature child when 12-16yrs:

Name: **Initials:** ☐ **M** ☐ **F**

Date of birth:

Name + signature parent/guardian:

Name + signature parent/guardian:

Name + signature child when 12-16yrs:

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Checklist voor de praktijkmedewerker

- Meerdere personen woonachtig op dit adres? Zo ja: zelfde huisarts
- Heeft patient zich laten uitschrijven bij vorige huisarts?
- Folder Zorg-onlineapp meegeven
- LSP: deze gegevens ook voor de apotheek klaarleggen.

Checks door de praktijk	**Datum**	**Paraaf**
COV		
Invoeren NAW in MHIS		
Melding werkblad in MHIS		
Dossier ingelezen		
Ruiters toegevoegd		
Actueel Medicatie Overzicht opgevraagd bij vorige apotheek		
Genoemde allergieen doorgevoerd in dossier		
Toestemming LSP verwerkt		
Verificatie door huisarts		