****

**Registration form for new patiënts**

**Huisartsenpraktijk Acht**

Compleet te form below and het it in **signed**, you can give it to one of our assistants, togehter wit te **consent form for the LSP**

I hereby confirm that I since \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

|  |  |
| --- | --- |
| **My details** |  |
| Family name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Initials  Nickname | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of birth | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Gender | ○ Male ○ Female |
|  |  |
| **Address** |  |
| Address | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Zipcode, Town | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone (partents/guardian) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| BSN | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Health insurance | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Insurance number | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Former GP | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Nem pharmacy | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I give permission to request my medical file fort the previous GP Yes/No

**Emergency contact**

Name

Phonenumber

ind of relationship

Please complete a separate form for each person together with the attachment.

Your GP may first invite you for a consultation for an introductory meeting before the registration can be finalized. The main reason for tis is that, especially in the case of a complex medical history, we believe it’s important that there is a good basis for a mutual relationship of trust.

**Date:**

**Signature:**

Please let your previous GP known as soon as possible after confiramtion of your registration to send your medical data digitally to Medisch Centrum Beek en Donk.

**BVD. Huisartsenpraktijk Acht**

**Attachment 1:**

We always like to be informed about your health situation and therefore ask you to answer the following questions for us?

|  |  |
| --- | --- |
| **What is the reason you are going to another GP?** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Family situation?*:** | Married | Living together. | Single | Otherwise: |

|  |  |
| --- | --- |
| ***Is there someone in your residantial contaxt who is already registered in our practice?***  ***If your answer is yes, wich GP and what is the date of birth?*** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Did you have of had you suffer from*:** | | | | | | |
| *Diseases:* | | | *Ja/yes* | | *Nee/no* |  |
| Heart or vascular diseases: | | |  | |  |  |
| Lung diseases? | | |  | |  |  |
| Burn-out or depression? | | |  | |  |  |
| Liver or bowel diseases? | | |  | |  |  |
| Persistent joint complaints? | | |  | |  |  |
| Thyriod diseases? | | |  | |  |  |
| Other serieus illnesses? | | |  | |  | Wich? |
| STD? | | |  | |  |  |
| Undergo surgery: | | |  | |  | Wich?  When? |
| Are you being treated by a medical specialist? | | |  | |  |  |
| Are you taking any medicines? | | |  | |  | Wich? |
| Are you allergic to anything? | | |  | |  | Whatfor? |
| Are you using alcohol? | | |  | |  | How many units per day? |
| Are you using drugs? | | |  | |  | Which? |
| Have you been a victim of violence? | | |  | |  |  |
| Diabetic? | | |  | |  |  |
| High cholesterol? | | |  | |  |  |
| Hypertension? | | |  | |  |  |
| **Health risks:** | | | | | | | |
|  | *yes* | *No* | |  | | | |
| Smoking: |  |  | | How many sigarettes: | | | |
| When did you quit smoking? |  |  | | How many years: | | | |
| Weight: |  |  | |  | | | |
| Length: |  |  | |  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Wich diseases run in your family and in whom?** | | | |
|  | *Yes* | *No* |  |
| Diabetes mellitus |  |  |  |
| Hypertension |  |  |  |
| Heart and vascular diseases |  |  |  |
| Stroke |  |  |  |
|  | *Yes* | *No* |
| Lung diseases: |  |  |  |
| Mental illness: |  |  |  |
| Cancer: |  |  |  |
| Other diseases: |  |  |  |

**A consent form is included in the enclosed informatie booklet about exchanging medical data. Please ensure that tis is completed and submitted along with your registration form.**