Registration form

General practice Eshuis *17 Septemberplein 59a, 5691 DG Son en Breugel*
General practice de Groot en van de Velde *17 Septemberplein 59a, 5691 DG Son en Breugel*
General practice Panhuizen en van Galen *17 Septemberplein 59a, 5691 DG Son en Breugel*
General practice Bollen *17 Septemberplein 59a, 5691 DG Son en Breugel*
General practice Rijnlaan, Teunisse/Gijsbers *Rijnlaan 2, 5691 JH Son en Breugel*

Personal data

Surname: : MALE/ FEMALE
Firstname:
Initials:
Given name(s):
Date of birth:
Place of birth:
Family composition:

Address:
Zipcode/City

Mobile phone number:
Other phone number:
E-mailaddress:

BSN number:

Insurance:
Policy number:

Profession:
Desired pharmacy:

If your partner is already registered in our practice, please mention their name, date of birth and doctor:

If desired, you can indicate a preference for a practice but we cannot always guarantee:

Permission for file transfer

Hereby I give permission, to ask my previous doctor to send my medical file to my new doctor.

Name previous doctor:
Address, zip code/city:
Phone number:
Fax number:

Date: *Signature:*

The purpose of this questionnaire is to have your medical details known to us as fully as possible.
Each family member receives their own questionnaire.

Medical data

Did you ever have a surgical intervention?
- No
- Yes, please specify:

Do you have any chronic disease? (if yes, please specify)
- Diabetes
- Pulmonary disease, like astma / COPD
- Cardio and vascular disease
- Hypertension / high bloodpressure
- Other, please fill in:

Do you take medication?
If yes, please specify (which one / dosage / use):

Previous hospital admissions + treatments
- No
- Yes please specify:

Are you under control by a practice nurse?
- No
- Yes, for: Diabetes Mellitus / Astma / COPD / hypertension

Do you have any psychiatric diseases?
- No
- Yes please specify:

Did you have any help, if yes please specify: (bv GGZ / psychologist)

Allergies or intolerance to medications?
- No
- Yes, please specify:

Risk factors

Do you smoke?
- No
- Yes → how many:
- In the past: ... years ago

Do you drink alcohol?
- No
- Yes → how many glasses a day:

Are there diseases present in your family?
- Heart attack
- Hypertension/blood pressure
- TIA
- Blood vessel operations
- Diabetes
- Pulmonary disease like astma / COPD / Chronic bronchitis

Are there several cases in your family:
- Breast cancer
- Colon cancer
- Hereditary (metabolic) diseases? If yes, please specify:

Is there anything else important for us to know?
If yes, please specify:

We would like to receive a copy of your identify and insurance certificates with this registration form. After processing your data, the copies of your identify and insurance certificates will be destroyed in accordance with the Privacy Act.

Next month you will get a written notification about your entry in our practice.

Permission form

Your medical data available through the LSP

volg je zorg

☐ YES

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)' brochure / leaflet. **YES:** I have read and understand all the information in the 'Your medical data available through the LSP (National Exchange Point)' leaflet.

☐ NO

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)' brochure. **YES:** I have read and understand all the information in the 'Your medical data available through the LSP (National Exchange Point)' leaflet.

GP or pharmacy details

Which healthcare provider does the form concern? ☐ **my GP** ☐ **my pharmacy**

Name: .....

Address: .....

Postcode and town: .....

My details do not forget to sign the form.

Family name: ..... **Initials:** ..... ☐ **M** ☐ **F**

Address: .....

Postcode and town: .....

Date of birth: ..... **Signature:** .....

Date: .....

Do you wish to arrange permission for your children?

- For children up to age 12: the parent or guardian gives permission. Please use this form.
- For children aged 12 to 16 who wish to give their permission: both the parent or guardian and the child need to sign this form.
- Children aged 16 and over need the give permission themselves and fill-out their own form.

Details of my children

Complete the below details of the children with respect to whom you wish to give permission.
do not forget your own signature.

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 complete a new permission form.

Signature parent or legal guardian: ..... **Date:** .....