(Door assistente in te vullen)
Aangenomen door:
Controle ION:
LSP/OPT-in:
In admin agenda:
MGN:

Medisch Centrum Oud-West

Registration form new patient

(1 form per patient)

First name: .....

Initials: .....

Surname: .....

Gender: O Male O Female O Other, ...

Date of birth: .....

Nationality: .....

ID-number: .....

Type ID: O Passport O ID-card O Drivers-license O Residence document

BSN-number: .....

Address: .....

Zip code: .....

City: .....

Phone number: .....

E-mail address: .....

Health insurance: .....

Insurance number: .....

New pharmacy: .....

Do you have a preference for a general practitioner? O No O Yes, ...

Name previous general practitioner: .....

Address previous general practitioner: .....

Have you ever been registered in our practice before? O No O Yes

Do you agree to requesting your medical file from your previous GP? O No O Yes

Signature: **Date:**

Please bring a valid ID and a health insurance card with you when submitting the registration forms

Medisch Centrum Oud-West

Consent to exchange patient data

With this form you can indicate whether you give permission to a healthcare provider to have the data in your patient file viewed by other healthcare providers.

☐ **YES**, I give permission for my GP to make my medical data available to the practitioners/care providers relevant to me.

☐ **No**, I do not agree to my GP making my medical data available to the practitioners/care providers relevant to me.

My details

First name..... Surname.....

Date of birth..... BSN no.....

Address .....

Postal code..... Residence.....

Data for children under 16 years of age. Children aged 16 and over complete their own form.

For children under the age of 16 who are under your authority, you can fill in the following information. Children between the ages of 12 and 16 also require their own consent. They must co-sign this form.

Name of child 1.....

BSN no. .....

Date of birth.....

Signature of child 1, only necessary for ages 12 to 15 years .....

Name of child 2 .....

BSN no. .....

Date of birth.....

Signature of child 2, only necessary for ages 12 to 15 years .....

Name of child 3 .....

BSN no. .....

Date of birth.....

Signature of child 3, only necessary for ages 12 to 15 years .....

Siganture

Date en place ..... Your signature .....

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First and surname .....

Date of birth: .....

O Single O Living together/married O Widow(er)

Current profession/education: .....

Do you have the following conditions? If so, since when?

		Since when:	Under treatment at:
High bloodpressure	Yes/No*		GP/Practice nurse/specialist*
Diabetes	Yes/No*		GP/Practice nurse/specialist*
Asthma/bronchitis/COPD	Yes/No*		GP/Practice nurse/specialist*
Heartcondition	Yes/No*		GP/Practice nurse/specialist*

* cross out what is not applicable

Are you currently taking any medications, including medications such as the contraceptive pill or sleeping medication?

O No O Yes: .....

Are there any medications that you cannot tolerate or are allergic to?

O No O Yes: .....

Are you under the supervision of a specialist or therapist?

O No O Yes: .....

If there is anything else you think we should know or if you would like an introductory meeting, you can contact the assistant one week after submitting your registration forms.

Huisartsen Marialaan 250:

HIDHA Tjitske Reinards	T.024-3774651
Dennis Kienhuis	T.024-3771759
Manon van Schijndel	T.024-3730020
Iris klein Breteler	T.024-3770366

Huisartsen Marialaan 350:

Linda Kiers	T.024-3775696
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