**Huisartsenpraktijk Bergse Bos** REGISTRATION FORM

Van Beethovenlaan 60

3055 JD Rotterdam

### Tel. 010 – 303 1800

## PERSONEN (NB: nummers vindt u op de verzekeringspasjes)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Initials | First name | Surname | m/f | Date of birth | Social Security number | Insurance Company | Insurance policy number |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

ALGEMENE GEGEVENS

|  |  |
| --- | --- |
| Street + house number |  |
| Post code |  |
| Telephone number | 010 -  |
| Mobile number(s) | 06 - t.n.v. | 06 - t.n.v. |
| E-mail |  |  |
| Desired chemist |  |
| Previous doctor |  |
| + address |  |

DATE: SIGNATURE:

**Huisartsenpraktijk Bergse Bos**

**Van Beethovenlaan 60**

**3055 JD Rotterdam**

**Tel. 010-3031800**

DECLARATION OF REGISTATION

Name ………………………………………………………………….

Date of Birth ………………………………………………………………….

Social Security nr. ………………………………………………………………….

|  |  |  |
| --- | --- | --- |
| Name of other family members | Date of Birth | Social security nr. |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Is registered since ………………………………….with:

Praktijk Bergse Bos en huisarts W.D. Boswinkel

Van Beethovenlaan 60

3055 JD Rotterdam

Tel: 010 – 303 1800

And hereby requests:

|  |  |
| --- | --- |
| Name previous doctor |  |
| Address |  |
| Postcode and City |  |
| Telephone |  |

To deregister him/her (and other family members if appropriate) from their medical practice and to pass on all medical records, if possible electronically (we use Medicom)

Signature: Date:

…………………………….. ………………………..

We would appreciate it if you would fill in this form about your health. If your household consists of more than one person, please have a separate one for each person to fill in a form.

|  |  |
| --- | --- |
| Name |  |
| Date of birth |  |
| Identification |  Passport Drives license, number: |
| Marital status | single / living together / married / divorced / widowed  |
| Religion |  |
| Nationality  |  |
| Study discline / profession |  |
| Profession | werkzaam/werkeloos/arbeidsongeschikt/gepensioneerd sinds: |
| Donor codicil | no / yes |
| Euthanasia passport | no / yes since: |
| I give my healthcare provider permission to share my data via the LSP | O Yes, I agreeO No, I do not give permission |

1. Do you have one or more of the following conditions and for how long?

O Diabetes

O Lung disease: asthma, COPD or other .......................................................

O High blood pressure

O High cholesterol

O Cardiovascular disease, namely .......................................................

O Psychiatric illness, namely .......................................................

O Ailments of the liver or intestines, namely .......................................................

O Chronic symptoms of the joints

O Sexually transmitted disease, namely .......................................................

O Kidney disease

O Thyroid problems

O Gestational diabetes

O Preeclampsia

O Other illness, namely .......................................................

1. Are you currently being treated by a specialist?

O No

O If yes, please fill in the table below

|  |  |  |
| --- | --- | --- |
| Name specialist | Which hospital | For what treatment |
|  |  |  |
|  |  |  |
|  |  |  |

1. Have you ever had an operation?

O No

O Yes, please list any operations in the following table

|  |  |
| --- | --- |
| Date of operation | Operation |
|  |  |
|  |  |
|  |  |

1. Do you currently take any medicine?

O No

O Yes, Please list the medicines in the following table

|  |  |  |
| --- | --- | --- |
| Medicine name | Strength | Dosage |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. Are you hypersensitive (allergic)?

O No

O Yes, for medicine, namely ........................................................................

 Specific food or drink, namely ….............................................................

 Other, namely ........................................................................

1. Do you smoke?

O No

O Yes, ...... cigarettes/shag/cigar/pipe per day

O Stopped since: ………………….

1. Which illnesses are in the family and who suffers from them (father/mother/brother/sister /grandparent on mother’s side etc.)?

O Diabetes by whom: …………….…………………………………………………….

O High Blood Pressure by whom: …………….…………………………………………………….

O High cholesterol by whom: …………….…………………………………………………….

O Cardiovacsulair disease by whom: …………….…………………………………………………….

O Stroke or brain hemorrhage by whom: …………….…………………………………………………….

O Lung disease: asthma/COPD by whom: …………….…………………………………………………….

O Kidney disease by whom: …………….…………………………………………………….

O Psychiatric illness by whom: …………….…………………………………………………….

O Cancer + type of cancer by whom: …………….…………………………………………………….

1. Please mention here anything that you think that your doctor should be aware of:

.....................................................................................................................

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#### Thank you for completing the questionnaire.

**Huisartsenpraktijk Bergse Bos**

**Van Beethovenlaan 60**

**3055 JD Rotterdam**

**Tel. 010 – 303 1800**

Dear Sir or Madam,

Welcome to our practice:

In order to be able to provide an optimal health service we require certain information about
you and your family. Please complete this registration form and return it **in person** to the practice together with **a copy of your medical insurance card and passport or other form of identification**.

Unfortunately we are unable to process registration forms that are not handed in personally.

*Please ensure that your previous doctor is informed that you are registering with a new*

*doctor, please ask him/her for your medical records. The current Medical Insurance*

*legislation does not allow you to be registered with more than one family doctor at any one*

*time.*

Our fees are accordance with NZA guidelines. If you are insured with a Dutch medical

insurance company we will declare our fees directly with your medical insurance company.

We will send you a bill for any costs that we cannot claim from your medical insurance

company or if you are not insured with a Dutch medical insurance company.

Please complete a separate copy of 3- 4 of this form for each member of your household.

**W.D. Boswinkel,**