huisartsencentrum
hillegersberg

DECLARATION OF REGISTRATION

The undersigned,

Name ……..

Date of Birth ……..

Social Security Nr ……..

Name of other family members	Date of Birth	Social Security Number

Is registered since …….. with:

Doctors' Practice BF van Leenen
Minervaplein 2b
3054 SK Rotterdam
Fax. 010- 4181863

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

……. ……..

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Minervaplein 2b
3054 SK Rotterdam

Dear Sir or Madam,

Welcome to the following practice:

- **B.F. van Leenen**

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*.

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

If you were previously registered with a doctor in the Netherlands please inform him/her that you are now registered with the above family practice.
The current Medical Insurance Legislation does not allow you to be registered with more than one family doctor at any one time. After receiving the completed registration form(s) we will register you (and family members) in our practice and report this to your health insurance provider. A copy of this information will automatically be sent to your previous doctor who will then be able to send us your medical records electronically.

Our fees are in accordance with NZA guidelines. If you are insured with a Dutch medical insurance company we will claim our fees directly from 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 this form for each member of your household.

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3054 SK Rotterdam

REGISTRATION FORM

Surname	
Street and house number	
Post code	
Telephone number	
Male or Female	m / f
Date of birth	
Initials + first name	
Maiden name	
Insurance Company + UZOVI nr.	
Insurance policy number	
Social Security number	
Desired chemist	Hillegersberg / Beethoven / Schiebroekse apotheek / Medisch Centrum Schiebroek
E-mail	
Mobile telephone number	
Nationality	
Religion	
Study discipline / profession	
Marital status	single / living together / married / divorced/ widowed
Previous doctor (name, address)	
Donor codicil	no / yes
Euthanasia passport	no / yes since:

1. Do you have one or more of the following conditions and if so, when did it start?

   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 Other illness, namely ……..

2. Which illnesses occur in your family and who suffers from them (father /mother /brother /sister /grandparent on mother's side etc)? Please circle if applicable.

   O Cardiovascular disease — by: father / mother / brother / sister / grandparent on father's side / grandparent on mother's side

   O Breast cancer — by: father / mother / brother / sister / grandparent on father's side / grandparent on mother's side

   O Ovarian cancer — by: father / mother / brother / sister / grandparent on father's side / grandparent on mother's side

   O Intestinal cancer — by: father / mother / brother / sister / grandparent on father's side / grandparent on mother's side

   O Diabetes — by: father / mother / brother / sister / grandparent on father's side / grandparent on mother's side

   O High cholesterol levels — by: father / mother / brother / sister / grandparent on father's side / grandparent on mother's side

   O Your Mother was prescribed DES during pregnancy: yes / no

3. Are you hypersensitive (allergic)?
   O No
   O yes, for medicine, namely.....
   Specific food or drink, namely.....
   Other, namely ….....

4. Do you smoke?
   O No
   O Yes, ... cigarettes/shag/cigar/pipe per day
   O Stopped since: …….

5. Have you ever had an operation?
   O No
   O Yes, please list any operations in the following table

Date of operation	Operation

6. Do you currently take any medicine?
   O No
   O Yes, Please list the medicines in the following table

Medicine name	Strength	Dosage

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

Your medical data available through the LSP (National Exchange Point)

Your GP can share important information about your health with other healthcare providers. But only with your explicit permission. And even with your consent these other healthcare providers may only view your data if it is necessary for your treatment. You can ask the assistent for the brochure or visit www.volgjezorg.nl/en

O YES , I do authorize my GP making my data available through the LSP.

O NO, I do not authorize my GP making my data available through the LSP.

Signature **Date**