**REGISTRATION FORM HUISARTSENPRAKTIJK MILAN**

Dierenselaan 14, 2573KH, Den haag

T: 070-3624082 F: 070-3605948

**MEDICOM CODE: BC**

Last name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initial(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M/F\_\_\_\_\_\_\_

Maiden name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postal code/Residence:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel. home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel. cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health insurer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last GP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Address/Residence:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Details of your partner and/or child(ren) who also register (SAME ADDRESS!)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Last name/Initials** | **M/V** | **Date of birth** | **BSN** | **Health insurer** | **Policy number** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

We need a copy of ID and Policy from everyone who wants to register!

You deregister yourself with your previous GP AND ask him/her to transfer your medical file to us!

**WARNING: Your registration can only be completed when we have your medical file**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical intake form**

**Weight: . . . . . . KG Length: . . . . . Cm Profession: . . . . . . . . . . . . .**

Do you suffer from one of the following conditions:

|  |  |
| --- | --- |
| * Diabetes * Asthma * COPD * High bloodpressure * Thyroid diseases * Epilepsy | * Heart and vascular disease * Type of cancer * Liver, stomach or intestinal disease * Depression or other psychic illness * Organ transplant or major surgery * Any other medical condition |
| Do these diseases also run in your family ? ............................who?.....................  ............................who?..................... | |

|  |  |
| --- | --- |
| Do you use medication?   * Yes   1.………………………………………………………..  2.……………………………………………………….. | * No   3.………………………………………………………..  4.……………………………………………………….. |

Are you allergic to some medicines

* No
* Yes ………….…………………………………………..……………………………………………………………..

Any other major allergies…………………….…………..……………………………………………………………..

Are you currently being treated by a medical specialist?

|  |  |
| --- | --- |
| * No | * Yes, specialty………..…………………………………………………………………. |

Do you participate in the flu vaccination program?

|  |  |
| --- | --- |
| * No | * Yes, because……..……………………………………………………….……………… |

Do you smoke?

|  |  |
| --- | --- |
| * No, i never smoked * Yes………cigarettes per day | * Not any more, stopped since…………………….. |

**I give permission to make my data available for consultation by doctors on night and weekend shifts, the pharmacy and hospitals (see LSP)**

|  |  |
| --- | --- |
| * **Yes i give permission** | * **no** |

Additional important information:

…............................................ Date ………..... / ……..….. / ……..…..

Signature (if minor, signed by legal representative)