HUISARTSENPRAKTIJK
Hapert & Hoogeloon

Registration form for new patients

When you register as a patient in our practice, it is important that we quickly gain insight into your health status. We therefore ask you to complete this form for each family member and submit it to the assistant. Take your ID or Passport with you. We also request you to inform your current GP of the transfer. This is the fastest way to receive your file.

Last name:	
Maiden name:	
Date of birth:	
Initials:	
First name:	
Gender:	Male ☐ Female ☐
Social Security Number: (BSN)	
Passport/ID Number:	
Marital Status:	
Address:	
Street:	Number:
Zip code:	
City:	
Phone number:	Mobile number:
E- mail:	
Insurance information:	
Name of health insurance:	
Insurance number:	UZOVI number:
Details previous GP:	
Name:	
Place:	
Phone number:	
Details previous pharmacy:	
Name:	
Place:	
Phone number:	

Do

Do you give permission to your previous GP to send your medical data and to deregister from his or her practice?

☐ Yes ☐ No

Do you give permission for your medical data to be exchanged between healthcare providers (LSP, Landelijk Schakel Punt)?

This is for he GP post in the evening/weekend, more information at www.volgjezorg.nl.

☐ Yes ☐ No

I hereby declare that I am registered as a patient in Huisartsenpraktijk Hapert & Hoogeloon:

Place: ……., ……-……-…… (date)

Name: …… Signature: …….....

(for children under 12 years of age, signature by parents or guardian required)

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Medical data: (*circle what applies)

Do you have an allergy? Yes / No *. If so , for: ……

Do you smoke? Yes / No *. If so, since: …….. (year) ……..cigarettes a day

Do you use alcohol? Yes / No *. If so, number of drinks per day: ……..

Do you receive flu vaccination? Yes / No *. If so , because of: ……..

Do you have any chronic diseases:

	Yes/No	Since:	Treatment by GP/Practice assistant/Specialist.
Cardiovascular disease			
High bloodpressure			
Increased cholesterol			
Diabetes			
Asthma			
COPD			

Other major diseases: (state whether you are treated by a specialist for this)
……
……
……..
Have you had any surgical procedures?: Yes / No *. If so which one and in what year?:
……
……
……

Medication use (both self-medication as prescription medication)

	Medication name	Dosage (mg or ug, etc)	Usage
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

The following persons, at the same address are already registrated in this practice:
(only complete if applicable)

Name:……Date of birth:……..

Name:……....Date of birth:……..

Name:……Date of birth: ……..