# Inschrijfformulier Huisartsenpraktijk Randwijck

## ADULT

Dear madam, sir,

In order to provide you with optimal care, we need some information from you. Would you please fill in this form as completely as possible? If you have any questions, you can contact our assistants. If you have space too short, you can further add this in the space "other comments" on the last page.

| **Personal** | | | |
|---|---|---|---|
| surname | | initials | |
| maiden name | | first name | |
| date of birth | | gender | |
| civil status | | | |
| **Adress** | | | |
| street | | number | |
| residence | | zip code | |
| e-mail | | | |
| telephone | | | |
| **Insurance and identity number (BSN)** | | | |
| insurance company | | | |
| policy number | | | |
| identity number (BSN) | | | |

| **Previous general practitioner** | | | |
|---|---|---|---|
| name | | telephone | |
| adress | | | |
| I request my previous practitioner to transfer my medical records to my new general practitioner | | | |
| **signature** | | **date** | |

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| **Current pharmacy** | | | |
|---|---|---|---|
| name | | telephone | |
| adress | | | |
| We work intensively with the Randwijck pharmacy, do you want to take this pharmacy as your new pharmacy? | | □ yes | □ no |

| **Medication** | **Welke medicijnen gebruikt u?** | |
|---|---|---|
| substance name | dose (mgs) | number per day / week |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Allergies** | **Do you have any allergies?** |
|---|---|
| □ penicillin / other antibiotics<br>□ other medications | □ latex / band-aids<br>□ iodine |
| □ other (please explain) | |

| **Medical history**<br>please provide below | **What conditions or diseases do (or did) you suffer from?** |
|---|---|
| -<br>-<br>-<br>-<br>- | -<br>-<br>-<br>-<br>- |

| **Surgical history**<br>operation | year | hospital/specialist |
|---|---|---|
| | | |
| | | |
| | | |

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| **Family history** | **Which diseases are present your family?** |
|---|---|
| □ hypertension | □ colon cancer |
| □ high cholesterole | □ breast cancer |
| □ hearth attack | □ prostate cancer |
| □ stroke | □ other cancers |
| □ diabetes | □ renal diseases |
| □ other (please explain) | |

| **Chronical conditions** | **Were you treated by the practice nurse in you previous practice?** |
|---|---|
| □ no | □ yes, voor asthma / COPD |
| □ yes, for diabetes | □ yes, for elderly care |
| □ yes, for hypertension/cardio vascular diseases | □ yes, for psychological problems |

| **Lifestyle** | |
|---|---|
| Do you smoke? □ no | □ yes, ± cigarettes per week |
| Do you drink alcohol? □ no | □ yes, ± units per week |

| **Privacy** | | |
|---|---|---|
| I give my doctor permission to make my medical records available via the National Switching Point (LSP). | □ yes | □ no |
| *If necessary, your most important medical data can be shared with other practitioners, such as the GP on duty, pharmacy or hospital. More information: https://www.volgjezorg.nl/en* | | |
| I give my doctor permission to contact me by e-mail for a satisfaction survey. | □ yes | □ no |
| *If you give permission, you will receive an electronic survey about once a year to help us improve our service. This is done by the company Qualiview, which processes the answers you provide anonymously. They have no access to your medical data.* | | |
| **Our complete privacy statement can be found on our website.** | | |

| **Children** | | |
|---|---|---|
| If you register with your minor child(ren) and you live permanently separated from the other parent, please provide details of the other authoritative parent: | | |
| name | adress | telephone |
| | | |

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| **Alert in case of emergency** | | **Important contacts** |
|---|---|---|
| name | relation | telephone |
| □ | | |
| □ | | |
| □ | | |
| □ *check if this person is allowed to speak / decide for you when you are unable to do so yourself* | | |

| **Treatment limitations** | **Are there treatment limitations?** |
|---|---|
| □ no<br>□ yes, no resuscitation | □ yes, no intensive care / mechanical ventilation<br>□ yes, no hospitalisation |
| □ yes, other (please explain): | |

| **Other remarks** | **Other things the doctor needs to know about you** |
|---|---|
| | |

| **To be completed by the assistant** | | **proactieve registratie ja/nee** | |
|---|---|---|---|
| identificatie | paspoort | rijbewijs | id-kaart |
| **Praktijk** | | | |
| Grie/Rol | WIT/LOI | DAA/LOE | DUN/ROL |