Registration new patient Family Practice "Schenkel" A

New patient details

Last name ..... Sex: ☐ Female ☐ Male

Initials / First name ..... Date of birth ...../...../.....

Address .....

Postal code and city .....

Mobile phone 06 - ..... Home Phone .....

E-mail .....

Emergency contact (name, phone no, relationship) .....

Burger Service Nummer BSN (*citizen service number*) .....

Insurance company and policy number .....

Marital status *(adults)* ☐ Married ☐ Divorced ☐ Widowed since .....
☐ Living together ☐ Single ☐ Registered Partnership

My pharmacy: ☐ Schenkel ☐ BENU Rozenburcht ☐ BENU Oostgaarde ☐ Schollevaar
☐ Spoorlaan ☐ 's-Gravenland ☐ other: .....

Details previous GP ***(general practitioner/huisarts)***

Name GP .....

City .....

Is your medical file known to us ? ☐ Yes, I brought it with me or it has already been transferred by my previous GP

☐ No, but on ...../...../..... (date) I have asked my previous GP to send my medical data to my new GP

☐ No, I still need to sort this out

As of today I want to register as a regular patient at:

Huisartsenpraktijk Schenkel
Bongerd 2, 2906 VK Capelle aan den IJssel
tel: 010-4512512 / fax: 010-4424364
AGB: 01052913

I* give my previous GP permission to transfer my medical data to the above medical practice.
I also hereby give permission to process the data about me and my health in the context of the care to be provided and to share data with other care providers, insofar as necessary for my treatment.

Date ...../...../..... Signature .....

** for children up to the age of 16, the legal representative must grant (co-)permission*

Please do not fill in below this line

☐ pt in mcom ☐ ONI ☐ verzekering ☐ WID ☐ ID documentnr : ..... RB / PP / IND
☐ ION ☐ dossier ontvangen ☐ dossier ingevoerd

KM ☐ j ☐ n

Medical data new patient

B

Name ..... Date of birth ...../...../.....

Illnesses and operations
(e.g. high blood pressure, diabetes, cerebral infarction/TIA, heart attack, appendectomy, asthma, broken leg, depression, migraine etc, etc)

What medicines do you use? (including inhaled medications, insulin and "as needed" medications)
Please also state the dosage (number of milligrams, number of times per day, etc)

Allergies

Other details/notes worth mentioning

Permission form

Your medical data available through the LSP

volg je zorg

☐ YES

I **do** authorize the below-mentioned healthcare provider making my data available through the LSP. I have read all the information contained in the 'Your medical data available through the LSP (National Exchange Point)' brochure / leaflet. **YES:** I have read and understand all the information in the 'Yes! I want to share my medical records; Give permission to share your medical records!' leaflet.

☐ NO

I **do not** authorize the below-mentioned healthcare provider making my data available through the LSP. I have read all the information contained in the 'Your medical data available through the LSP (National Exchange Point)' brochure. **YES:** I have read and understand all the information in the 'Yes! I want to share my medical records; Give permission to share your medical records!' leaflet.

GP or pharmacy details

Which healthcare provider does the form concern? ☐ **my GP** ☐ **my pharmacy**

Name: .....

Address: .....

Postcode and town: .....

My details Do not forget to sign the form.

Family name: ..... **Initials:** .....

Address: .....

Postcode and town: .....

Date of birth: ..... **Signature:** .....

Date: .....

Do you wish to arrange permission for your children?

- For children up to age 12: the parent or guardian gives permission. Please use this form.
- For children aged 12 to 16 who wish to give their permission: both the parent or guardian and the child need to sign this form.
- Children aged 16 and over need to give permission themselves and fill-out their own form.

Details of my children

Complete the below details of the children with respect to whom you wish to give permission. **Do not forget your own signature.**

Family name: ..... **Initials:** .....

Date of birth: ..... **Child's signature:** ..... ☐ YES ☐ NO

Family name: ..... **Initials:** .....

Date of birth: ..... **Child's signature:** ..... ☐ YES ☐ NO

Do you have more than two children? Please complete a new permission form.

Signature parent or legal guardian: ..... **Date:** .....

Submit this form to the GP of pharmacy your permission concerns.

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