GEZONDHEIDS CENTRUM *Binnenstad*

REGISTRATION

Welcome at our family practice.
You can register in our practice in case you reside in our working area (see website).
You can download this form and print it or pick up a registration form at the office.
Please hand in this form plus the questionnaire at the front desk.

The assistant will make an appointment with you for an introductory talk with the doctor.
Please bring your ID.

Last name, initials	Mr.				
First name					
Date of birth	Day	Month	Year		
Place/country of birth					
Address				Number	
Postal code			Utrecht		
Telephone					
E-mail address					
Name of previous family doctor					
Residence of previous family doctor					
New pharmacy					
Insurance company					
Polis-/clientnumber					
BSN number					
Number ID/rijbewijs					
Partner already registered?	No	Yes, name			
	Date of birth	Day	Month	Year	
Emergency contact	Name				
	Telephone number				

The undersigned hereby declares that starting Day Month Year he/she is registered as a patient at:
Gezondheidscentrum Binnenstad
Van Asch van Wijckskade 28
3512 VS Utrecht
AGB-code praktijk 055061

The undersigned hereby authorizes his/her new doctor to request for his/her medical record and history at the previous family doctor.
Please send the medical record/history via Zorgmail.
By signing you hereby give permission to exchange relevant medical information with both the pharmacy and the medical specialist.

Location		Date	Day	Month	Year
Signature		Signature			

Pay attention! If child <12 years old: parent/guardian must sign. If child is 12-16 years old: parent/guardian **and** child must sign.

GEZONDHEIDS CENTRUM Binnenstad QUESTIONNAIRE

Do you smoke?	☐ Yes ☐ No
Do you use alcohol and/or drugs?	☐ Yes ☐ No
If so, how much	

Do or did you suffer from any of the following diseases? If so, please elucidate

Cardiovascular disease (e.g. myocardial infarct, stroke, emboly, thrombosis)	☐ Yes ☐ No
If so, please elucidate	
Diabetes	☐ Yes ☐ No
If so, please elucidate	
Hypertension	☐ Yes ☐ No
If so, please elucidate	
Asthma/bronchitis	☐ Yes ☐ No
If so, please elucidate	
Cancer/malignancies	☐ Yes ☐ No
If so, please elucidate	
Psychological or psychiatric problems	☐ Yes ☐ No
If so, please elucidate	
High blood presure	☐ Yes ☐ No
If so, please elucidate	

Do you have a family history?

Cardiovascular disease by persons younger than 60 years	☐ Yes ☐ No
If so, who	
Diabetes	☐ Yes ☐ No
If so, who	
Hypertension	☐ Yes ☐ No
If so, who	
High cholesterol	☐ Yes ☐ No
If so, who	
Cancer	☐ Yes ☐ No
If so, who	

Traumatic experiences in the past

Current medication

Other relevant information

Permission form

volg je zorg

Your medical data available through the LSP

☐ 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: Gezondheidscentrum Binnenstad

Address: Van Asch van Wijckskade 28

Postcode and town: 3512 VS Utrecht

My details Do not forget to sign the form.

Family name: ..... **Initials:** ..... ☐ **M** ☐ **F**

Address: .....

Postcode and town: .....

Date of birth: Day Month Year **Signature:** .....

Date: Day Month Year

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:** ..... ☐ **M** ☐ **F**

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

Family name: ..... **Initials:** ..... ☐ **M** ☐ **F**

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:** Day Month Year

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

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