



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			
First name			
Date of birth			
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
Emergency contact	Name		
	Telephone number		

The undersigned hereby declares that starting 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			
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 QUESTIONNAIRE CENTRUM Binnenstad

Do you smoke?	Yes	No
Do you use alcohol and/or drugs? If so, how much	Yes	No
Do you have allergies If so, which one	Yes	No

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

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

Do you have a family history?

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

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?	<input type="checkbox"/> my GP <input type="checkbox"/> 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:	<input type="checkbox"/> M	<input type="checkbox"/> F
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:	<input type="checkbox"/> M	<input type="checkbox"/> F
Date of birth:	Child's signature:	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Family name:	Initials:	<input type="checkbox"/> M	<input type="checkbox"/> F
Date of birth:	Child's signature:	<input type="checkbox"/> YES	<input type="checkbox"/> NO

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

Signature parent or legal guardian:	Date:
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Submit this form to the GP of pharmacy your permission concerns.