**Registration form**

**Date:**

**Administrative data**

Last name:       Initials:

Date of birth:       Place/country of birth:

Address:       Postal Code:

Phone number home:       Mobile:

Insurance company:       Insurance number:

National ID number (BSN):

E-mailadres:

To verify your data we ask you to show your ID and your proof of insurance at the counter before registration

**Around 10,000 people living in Nieuwegein have problems filling in forms. Is someone else completing this form for you because you cannot do it yourself?**

[ ]  No

[ ]  Yes (we will try to take this into account)

**Permission to exchange medical data.**

If you need a doctor in the evening, night or weekend, it may be important for this doctor to be able to view your medical data, for example, which medicines you use, what you are hypersensitive to and what you have recently been to the doctor for. We can only share this data with the regional healthcare system if you give permission for this. Information about this can also be found on [www.VZVZ.nl](http://www.VZVZ.nl) or in the information brochure that is available in practice. Do you agree with the registration of your data for both general practitioner and pharmacy?

[ ]  Yes

[ ]  No

**Arrange your healthcare online when it suits you?**

You can use our online services via our website and the Zorg4Nieuwegein app. May we send you an invitation for this? This gives you access to your medical file

[ ]  Yes

[ ]  No

**Newsletter**

EMC Nieuwegein sends a newsletter about 4 times a year in which we inform you about the developments of Gezondheidshuis De Componist, the offer in the field of care and well-being and current issues. Would you also like to receive the newsletter? Then sign up [here](https://emcnieuwegein.us5.list-manage.com/subscribe?u=7be4d972c7d4849351f53ad0d&id=062de6880f).

**Name (new) pharmacy:**

**Previous doctor:**       in:

(Do not forget to request your medical data from the previous doctor).

Reason for registration:

**Adjusting the patient's hospital pass**

Do not forget to change your doctor on the hospital patient card

**Possible contact person in case of emergency:**

Phone number:

**Marital staus**

[ ]  Living alone

[ ]  Living together with:

[ ]  Married with:

[ ]  Divorced since:

[ ]  Widow/widower since:

**Do you have any children?**

[ ]  No

[ ]  Yes, living at home number:

[ ]  Ja, living away from home number:

**Profession**

[ ]  I have a job as:

[ ]  I am unemployed since:       my job was:

[ ]  I am incapacitated for work since:       my job was:

[ ]  I study field of study:

[ ]  I am retired

**Are there (for example from your belief) things that we need to take into account from a medical point of view?**

[ ]  No

[ ]  Yes, namely:

In order to properly organize your medical file, we ask you a number of questions that relate to your medical history.

**Health and diseases**

**Do you have (had) complaints from::**

[ ]  Diabetes

[ ]  Lung diseases

[ ]  High bloodpressure

[ ]  Cardiovascular diseases

[ ]  Venereal diseases

[ ]  Depression of anxiety

[ ]  Eating disorders

[ ]  Liver or intestinal diseases

[ ]  Joint complaints

[ ]  Immune disorders

[ ]  Thyroid diseases

[ ]  Skin disorders

[ ]  Kidney diseases

[ ]  Stress

[ ]  Other diseases, namely:

Explanation:

**Are you currently being treated by a specialist?**

[ ]  No

[ ]  Yes, specialism:       Disease:

**Have there been important medical events in your history, such as serious illnesses and operations?**

[ ]  No

[ ]  Yes, namely (Please indicate in which year you experienced this? You can also write it on the back of this form.)

**Do you use medicines?**

[ ]  No

[ ]  Yes, namely:

(add any medication overview)

**Are you hypersensitive (allergic)?**

[ ]  No

[ ]  Yes, for:

[ ]  Medicines, namely:

[ ]  Iodine / plaster / lidocaine (anesthetia):

[ ]  Certain food or drinks, namely:

[ ]  Other substances, namely:

**Do you have a donor codicil?**

[ ]  No

[ ]  Yes,

 (please note its contents of add a copy)

**Diseases in the family**

What diseases do your **parents**, **brothers** or **sisters** have?

[ ]  Diabetic Who:

[ ]  High bloodpressure Who:

[ ]  High cholesterol Who:

[ ]  Cardiovascular diseases under 65 Who:

[ ]  Stroke or cerebral haemorrhage under 65 Who:

[ ]  Lung diseases which:       Who:

[ ]  Kidney diseases which:       Who:

[ ]  Mental Illness which:       Who:

[ ]  Cancer which:       Who:

[ ]  Other diseases which:       Who:

**Are you currently concerned about your health or are there any issues that you would like to discuss with your doctor?**

[ ]  No

[ ]  Yes,

**Do you smoke?**

[ ]  Never did.

[ ]  Stopped after       years of smoking an average of       cigarettes /cigars per day.

[ ]  Yes,       cigarettes/cigars per day for       years.

**Do you regularly use alcohol?**

[ ]  No

[ ]  Yes, average number of units per day:

**Have you ever been a victim of physical / mental / sexual violence?**

[ ]  No

[ ]  Yes

[ ]  physical

[ ]  mental

[ ]  sexual

**Do you have a dependence on:**

[ ]  Medication

[ ]  Drugs

[ ]  Something else, namely:

**For women:**

**Do you use contraception prescribed by your doctor?**

[ ]  No

[ ]  Yes,

[ ]  Oral contraception,       (fill in which)

[ ]  Puncture pill, received last time on       (enter date)

[ ]  Spiral, Mirena / copper \* (\* delete what does not apply)

 Placed on       (enter date)

Are there any issues that are important to you and that have not yet been addressed?

Thank you for completing this form.

We strive to register you in our practice within 5-10 working days.