Mw. H.A.C.M Berends
Mw. C.Y. Man - Tang
Mw. W.M.J. van Esch
Dhr. G.H.L. Boereboom
Mw. M.A.C. Verschoor

General practitioners

APPLICATION FORM

Name new GP :…… Name pharmacy:…….

Registration date : …… - …… - 20……

Personal information:

Last name+ initials: ……(M / F)

Date of birth: ……-……-……

Address: ……

Postal code + city : ……..

Phone number : ……

Mobile number : ……E-mail address:……..

Insurance company : …… registration number: …….

Social security number (BSN):…….

Nationality / Country of origin:……

Which languages do you speak?

o English o Dutch o Other: …….

I **DO / DO NOT** agree with making my data available for consultation by other healthcare providers. For example: the replacement GP / 'Huisartsenpost'.

I **DO / DO NOT** want to use 'MijnGezondheid.net' (more information: www.Mijngezondheid.net)

Data former GP:
Name: ……

Address: ……

Postal code + city: ……

Phone number: ……

If you would like to meet your new GP, then our assistant will gladly make an appointment for you as soon as we have received your medical file from your former GP. **Please remember to bring valid identification to the first appointment.** Without identification we cannot finalize your registration with us.

I hereby declare that I am registered at practice Lidwina, Eindhoven starting from the above mentioned date. I consent to the transfer of my medical file.

……

(signature)

Please deliver this form to the practice, or send it by mail or e-mail.
Please send a copy of this form to your former GP.

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MEDICAL QUESTIONNAIRE

Please note! You do **not** need to complete the questionnaire if you are switching from a GP in the Netherlands to this practice. In that case, we will request your patient data from your former GP. In all other cases please fill in this form.

The purpose of this questionnaire is to ensure that we have as much of your medical information as possible. This questionnaire will not be shared with third parties. Please complete a separate registration form and questionnaire for every household member.

Do you suffer from any chronic illness and if so, are you being monitored by a practice nurse or specialist?
o No
o Diabetes
o Lung disease, such as asthma / COPD / other:
o Cardiovascular disease, such as a previous heart attack / stroke / vascular disease
o High blood pressure / cholesterol
o Mental health problems
o Other :

Do you have any allergies or intolerances? (including medication)
o No
o Yes, against :

Is there any other important information about your health that may be of interest to your GP?
o No
o Yes :

Do you use any medication? (If yes, which kind / dosage / use)
o No
o Yes :