# Registration form general practice Perron 1 part 1

Surname _____

Initials _____

Date of birth _____

M/F _____

Number IDcard/passport _____

Adress _____

Zipcode _____

Telephone number _____

Residential connection family / single / living together / students house

Pharmacy _____

Insurance name _____

Insurance number _____

Previous doctor: _____

**If more family members are signing up please disclose their person al information seperately below.**

Surname and initials / Name/ M/F / Date of birth / BSN/ Insurance + number

_____

_____

_____

_____

_____

**Please attach a copy of the identity card and health insurance policy for every patient enrolling.**

# Registration form general practice Perron 1 part 2

**Medical information Name:** **Date of birth:**

Do you suffer from any of the following conditions? If so, since when.

[] Diabetes
[] Lung diseases
[] High blood pressure
[] Cardio and vasculair disease
[] Thyroid diseas
[] Osteoporosis
[] Psychological symptoms
[] Remainder

**Are you currently under treatment by a specialist and if so for what medical condition:**

[] No

[] Yes specialis(m); _____
_____
_____

**Do you take any medications:**

[] No
[] Yes, namely: _____
_____
_____

**Are you allergic to:**

[] Medicines, if so what _____
[] Another substance and if so what _____

**Did you have a flu shot in the past year?**

[] No
[] Yes

**Do you smoke:**

[] Yes, .... cigarettes per day
[] No, not stopped since _____ ; before I smoked ____ cigarettes a day for ___years
[] No, I never smoked

**Do you drink alcohol:**

[] No
[] Yes Yes, _____ glasses per day

**Do you use drugs:**

[] No
[] Yes

Any additional information may be important for the general practioner

# Registration form general practice Perron 1 part 3

**Permission to exchange patient data**
By signing this form called 'share your medical information electronically consent form' you give your general practioner / general practice permission to share your information with other care providers.

**A separate form for each health care**
This form is valid for one care provider only. Do you want to grand promission to other care providers? Please download a blanc form for each care provider you want to grand permission via www.vzvz.nl

**Where can I return this form**
Please return this document to the general practitioner / general practice mentioned below.

**Information**
The brochure 'Sharing your medical information electronically?' provides a detailled discription on how your medical information will be shared. You can also contact your general practitioner, local pharmacy or hospital for more information or visit www.vzvz.nl

**General practioner**
Name general practioner: Perron 1 huisartsen Spoorlaan 374 5038DC Tilburg.

**My details**

Name _____ Initials_____M/F

Adress _____ Date of birth_____

Zipcode _____ Place_____

Telephone _____

**Permission**
[] Yes; I herewith grand permission to underneath mentioned care provider to share any relevant medical information with other care providers upon request. All whitin the guidlines mentioned in the brochure 'sharing your medical information electronically'

[] No; I do not grand premission to undern eath mentioned care provider to share any relevant medical information with other care providers upon request. All whitin de guidlines mentioned in de brochure 'sharing your medical information electronically'

**Signature**

Date and place Your signature

_____

**Data from partner and children**

Please provide all data for your partner and any childern still residing with you. They need to co-sign this form. Signing is not required for childern below the Age of 12.

1. Name_____
   Date of birth_____M/F Signature_____
   not required for children under 12 years

2. Name_____
   Date of birth_____M/F Signature_____
   not required for children under 12 years

3. Name_____
   Date of birth_____M/F Signature_____
   not required for children under 12 years

4. Name_____
   Date of birth_____M/F Signature_____
   not required for children under 12 years