**General practice Kraaij & Ensink**

Frankestraat 42

tel: 023-5322699

www.huisartsenkraaijensink.nl

**Registration form new patients**

Last name …………………………

initials ……………………… m / f first name. ……………………

Date of birth ……………………. place of birth / country …………

Street name …………………………. House number …………………...

Zipcode city …………………….

Tel. no. home …… ... ………………… Mobile phone no. …………………

Nationality ………………………….

E-mail ………………………………..

Name partner ..……………………..

Previous GP …………………… place ………………………….

Name of pharmacy in Haarlem and surroundings. …………………….

Insurance company ……………………

Insured number ………………………….

BSN number ………………………………… ..

**Family / living relationship**

° Living alone ° Living together ° Married

Do you have any children?

° No ° Yes …… girls ……. Boys living at home / away from home?

**Activities**

° I work as …………… ..

° I study, specialization …………

° I am retired …………

° I have been incapacitated for work since 20…., My work was …………
   cause of incapacity for work …………………………………

**Health and diseases**

Have you ever had complaints of:

° diabetes

Lung diseases (COPD, Asthma, TBC, chronic brochitis)

° high blood pressure

° cardiovascular diseases

° psychological complaints (depression, anxiety disorder, burnout)

° liver or intestinal diseases

° rheumatic diseases / arthrosis

° venereal diseases

° thyroid diseases

Allergies

° other serious illnesses ………………… ..

Are you currently being treated by a specialist?

 ° No ° Yes, for:

1. …………………………… Specialism ……………. Hospital ……………….

2. …………………………… Specialism …………… .. Hospital ……………….

Do you use medicines? If yes which one? (name, strength, usage per day)

° No.

° Yes 1 ……………………………………. 4 …………………………………

 2 ……………………………………. 5 …………………………………

 3 ……………………………………. 6 …………………………………

Are you hypersensitive (allergic) to?

° medicines ………………………

° certain food or drinks ………………

° other substances ………………………….

Have you ever experienced a major accident, major surgery or a longer hospital stay?

° major accident ……………………………

° operations ……………………………… ...

° admission to hospital ………………….

Do you smoke ? ° No ° Yes …… cigarettes per day

How many glasses of alcohol do you drink on average per week?

……… glasses per week ° Wine ° Beer ° Distilled

Do you use drugs? ° No ° Yes, which ………

**Diseases in the family**

Which diseases are in your immediate family?

° diabetes for whom ………………………

° high blood pressure in whom ………………………

° stroke or cerebral haemorrhage in whom ………………………

° heart or vascular diseases for whom ………………………

° asthma, COPD for whom ………………………

° mental illness for whom ………………………

° cancer in whom ……………………… type of cancer ………………

**For women only**

Has a Pap smear ever been done?

° No ° Yes, in 20 ……, result: ……….

Has there ever been a picture of the breasts (mammography)?

° No ° Yes, in 20 ……, result: ……….

I am aware of the pros and cons of connecting my medical

file on the LSP and I want to record the following choice:

I **do / do not** (please cross out what does not apply) permission to Kraaij & Ensink GP to connect my medical file to the LSP and Doc 2 Doc.

Leaflet permission LSP included: **YES / NO**

**I hereby register as a patient at General Practice Kraaij & Ensink.**

Name ……………………… Date of birth ………………………

Date ………………………

Signature ………………………

**After filling out the form, print it out and come to the practice with a valid ID.**

**Consent form
Making your medical data available via the LSP**

|  |  |
| --- | --- |
| YES  | NO |
| I do give permission to the healthcare provider below to make my data available via the LSP. I have read all the information in the folder "Your medical data available via the National Switch Point (LSP)".  | I do not give permission to the healthcare provider below to make my data available via the LSP. I have read all the information in the folder "Your medical data available via the National Switch Point (LSP)". |

General practitioner or pharmacy details
Which healthcare provider do you arrange permission for? □ my general practitioner
 □ my pharmacy

Name: ................................................
Address: ................................................
Zipcode and city: ..............................................

Do you want to give permission to another healthcare provider? Then request an additional consent form.

My data do not forget to put your signature

Last name: ................................................
Initials: ................ ................................ M / F
Address: ................................................
Zipcode and city: ..............................................
Date of birth: ....................................... Date:. ......................... Signature: ........................................

Do you want to arrange permission for your children?

• For children up to 12 years old: you give permission as a parent or guardian. You can use this form for this.

• For children from 12 to 16 years old who wish to give permission: both you and the parent or guardian and the child both put a signature.

• Children from 16 years of age give their own permission and fill in their own form.

My children's data

Enter the details of the children for whom you want to arrange permission below. Don't forget to put your own signature below.

Last name: ................................................
First Name: ................................................ M / F
Date of birth: .......................Child's signature: ................................................**YES / NO**

Last name: ..............................................................................
First Name: ................ ................................. M / F
Date of birth: ....................... Child's signature: ...............................................**YES / NO**

Do you have more than two children? Then request an additional consent form.

Signature parent or guardian: .............................................date:..................................................

Hand in this form to the doctor or pharmacy with whom you arrange permission.