Registration form

It is important that you fill out this questionnaire as complete as possible.
Please bring a valid ID card whit you when you return this form.

First and Family name:	
Date of birth and gender:	☐ Male ☐ X ☐ Female
Address and house no:	
Postal code and city:	
Telephone + Mobilenumber:	
E-mail address:	
Burgerservice number/social security no:	
Health insurance and policy number:	
Country of birth:	
New pharmacy:	☐ Benu pharmacy 't Hout ☐ otherwise:…….
Previous general practitioner and medical practice name	

Medical data	**Yes**	**No**	**If your answer is yes please explain here:**
Do you receive treatment from a physician?			
Do you have a (chronic) disease?			
Use of medication or the (contraceptive) pill?			
Do you now or had a history of depression or another psychiatric problem?			
Is your family known for hereditary diseases? (such as diabetes mellitus, cardiovascular diseases cancer)			
Did you ever have surgery?			
Do you receive radiation therapy, chemo therapy or did you ever receive these treatment before?			
Do you have any allergies?			
Do you have a "do not resuscitate statement" or a "living will"?			
Do you currently have complaints about your health?			
Do you annually receive an invitation for the influenza vaccination?			

Is your partner or roommate already patiënt at our practice and lives at the same address as you, please note the name and date of birth:

A introduction interview is possible as soon as your medical file has been received.

Date: ……. **Signature: ……**
(parent/authorised person)