*Registration form general practice*

*Huisartsenpraktijk Berent Avercamp*

Surname ..................................................... M / F
Initials / Firstname .....................................................

Date of birth .....................................................

Street, number .....................................................

Postal code and town .....................................................

BSN-number …………………………………………………

Telephone number .....................................................

Email address ………………………………………………….

Name health insurance .....................................................

Policy number .....................................................

Occupation .....................................................

**Are you coming to live with someone who is already a patient in our practice?** Yes / No

If yes, please fill in details of your relative

Name: .....................................................

Date of birth: .....................................................

Registration Date.................................. Signature................................

**Partner**

Surname ..................................................... M / F
Initials / Firstname .....................................................

Date of birth .....................................................

BSN-number …………………………………………………

Telephone number .....................................................

Email address ………………………………………………….

Name health insurance .....................................................

Policy number .....................................................

Occupation .....................................................

Registration Date.................................. Signature................................

* **When submitting this registration form, please include a copy of your identification**
* **Only a fully completed form will be processed**
* **Are your childeren 16 years or older? Please submit a separate form.**

**Please fill in the details of the other family members below**

**(under 16 years of age).**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Name | Date of birth | M/F | Insurance | Policy number | BSN:  |
| 1 |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |

|  |  |
| --- | --- |
| **Which GP do you want to register with?*** L. Snel
* M. Reitsma
* S.O. Driessen
* R. van der Hoef
 | **Which pharmacy are you registered with?*** Brun Aqua
* Ebbingepoort
* Flevowijk
* De Wetering
 |

**Have you been a patient here before?** Yes / No

If yes, whoe is your GP? .....................................

**Do you have home care?** Yes / No

If yes, from which organization? …………………………….......

**Do you have care through WLZ (Wet Langdurige Zorg)?** Yes / No

If yes, which institution provides the care? …………………………………..

If yes, which CIZ indication do you have? …………………………………..

**Permission to request medical data from previous GP**

|  |  |
| --- | --- |
| We ask you to give permission to request your file form your previous GP. | [ ] **YES** I give permission to request my file from my previous GP[ ] **NO** I do not agree to my file being requested from my previous GP |

**Details of previous GP**

Name of previous GP .....................................................

Address/town of previous GP .....................................................

*Registered patients must also inform their previous general practitioner of changing to Huisartsenpraktijk Berent Avercamp.*

**Consent LSP**

|  |  |
| --- | --- |
| We ask you to give permission for the exchange of medical information with the GP post and pharmacy*(see for more information www.ikgeeftoestemming.nl)* | [ ] **Yes** I give permission to my GP to make my medical data available to the practitioners/care providers relevant to me.[ ] **NO** I do not agree to my GP making my medical data available tot he practitioners/care providers relevant to me |

**Consent registration MGN**

|  |  |
| --- | --- |
| We ask you to give permission to register with MGN (=MijnGezondheidsNet).You will then have access to your own medical file. | [ ] **YES** I give permission to register with MGN[ ] **NO** I do not consent to registering with MGN |