**Registration form**

*(each person one form)*

|  |  |
| --- | --- |
| surname (birth name) |  |
| name partner |  |
| Initials/ first name | / |
| date of birth |  |
| female/ male | F/ M |
| nationality |  |
| social security number / burgerservicenummer (BSN) |  |
| address / house number | / |
| zip code / city | / |
| phone number |  |
| name and phone number in case of emergency |  |
| marital status |  |
| occupation |  |
| insurance company/ insurance number |  |
| permission for on call general practitioners  to check your medical records during evening/ weekend hours. | Yes /No |
| e-mail address |  |

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| --- | --- |
|  | |
| Name :  Date: | |
| Subscribes as a patient at Medisch Centrum Zwanenburg. Please show a valid proof of identity upon subscription. |  |
|  | |
| Signature:  Name/ address former GP in The Netherlands:  I give permission to transfer my medical records  Name and address former GP:  Signature: | |
|  | |
| **Medical record**   |  |  |  | | --- | --- | --- | |  | Do you have any of the following  diseases? If so, since what year? | And what about your direct family/ siblings? If so, what age did they have at diagnosis? | | hypertension |  |  | | cardiovascular disease |  |  | | pulmonary disease |  |  | | kidney disease |  |  | | stomach or intestinal disease |  |  | | diabetes |  |  | | recurrent bladder infections |  |  | | cancer |  |  | | psychiatric disease |  |  | | Are you allergic to any drugs or iodine? If so, what? | | | |  | | | | Have you ever had surgery or have you ever been hospitalized? If so, what for? | | | |  | | | |  | | | | Are you currently being treated by a medical specialist? If so, by whom and what for? | | | |  | | | |  | | | | Do you use drugs? If so, which one? | Name | daily dosage | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | Are there other things we should be aware of? | | | |  | | | | |
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