**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 |  |

|  |
| --- |
|  |
| 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 recordsName and address former GP: Signature:  |
|  |
| **Medical record**

|  |  |  |
| --- | --- | --- |
|  | Do you have any of the followingdiseases? 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 |
|  |  |  |
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|  |  |  |
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|  |  |  |
| Are there other things we should be aware of? |
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