

REGISTRATION FORM HUISARTSENPRAKTIJK PANTA RHEI

You would like to register yourself as a new patient to Huisartsenpraktijk Panta Rhei. Welcome!

Complete this form and the questionnaire Preventive quality care.

Hand in the completed form at our desk or send it by post (see address below, don't forget the stamps). In order to protect your personal and health data, we strongly advise you not to send this form by e-mail.

Ask your former general practitioner to send* us your medical file or to give it to you?

Registration per date ___ - ___ - _____

Lastname

First names

Geslacht male female

Date of birth ___ - ___ - _____

Social security number (BSN) _____

Home adress

Postal code and city

Phone number

Mobile number 0 6 _____

E-mailaddress

Health insurance company

Insurance number

Name pharmacy

Address pharmacy

Connect to LSP yes no

* Medical files are transferred via Zorg File Transfer, a secure application used by most general practitioners in the Netherlands.

QUESTIONNAIRE PREVENTIVE QUALITY CARE

Huisartsenpraktijk Panta Rhei would like to provide optimal care on your health. That means that we want to pay attention to your health now and in the future. This is called *preventive quality care*. Therefore we kindly ask you to complete the questionnaire below. This questionnaire will of course - just like your other medical details - be treated confidentially. You can hand the questionnaire together with the registration form at the desk or send it by post.

Initials (if child firstname):

Lastname:

Date of birth: ____ - ____ - ____

Occupation:

Have you had major illnesses in the past? yes no

If yes, which?

.....

.....

Have you ever been admitted to a hospital? yes no

If yes, when and what for?

.....

.....

Do you have:

- high blood pressure yes no
- high cholesterol levels yes no
- diabetes yes no
- heart- and/or vascular disease yes no
- COPD yes no
- asthma yes no

Do you have an allergy or hypersensitivity to certain medicines?

yes no

If yes, which medication?

.....
.....

Do you currently use medication?

yes no

If yes, which?

.....
.....

Do you smoke:

yes no

Do you drink alcohol:

yes no

Do you have a medical indication for an annual flu vaccination?

yes no

Are you familiar with the following diseases in your family?

- Heart- and/or vascular disease yes no
- Diabetes yes no
- Asthma/COPD yes no
- Cancer (lung, prostate, ovary, intestine, breast) yes no
- Depression yes no
- Other diseases, namely

Are there any genetic disorders in your family?

yes no

If yes, which?

.....
.....

Please list below things that you think are important for your doctor to know?

.....
.....
.....
.....

IMPORTANT!

Ask your previous doctor to send us your medical file.