Huisarts W.D Boswinkel  
van Beethovenlaan 60  
3055 JD ROTTERDAM  
010- 3031800

DECLARATION OF REGISTRATION

Name ………………………………………………………………….

Date of Birth ………………………………………………………………….

Social Security nr. ………………………………………………………………….

|  |  |  |
| --- | --- | --- |
| Name of other family members | Date of Birth | Social security nr. |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Is registered since ………………………………….with:

And hereby requests:

|  |  |
| --- | --- |
| Name previous doctor |  |
| Address |  |
| Postcode and City |  |
| Telephone |  |

To deregister him/her (and other family members if appropriate) from their medical practice and to pass on all medical records, if possible electronically (we use Medicom)

Signature Date

…………………………….. ………………………..

Huisarts W.D Boswinkel  
van Beethovensingel 60  
3055 JD ROTTERDAM  
010- 3031800

Dear Sir or Madam,

Welcome to our practice:

In order to be able to provide an optimal health service we require certain information about you and your family. Please complete this registration form and return it **in person** to the practice together with **a copy of your medical insurance card and passport or other form of identification**.

Unfortunately we are unable to process registration forms that are not handed in personally.

*Please ensure that your previous doctor is informed that you are registering with a new doctor, please ask him/her for your medical records. The current Medical Insurance legislation does not allow you to be registered with more than one family doctor at any one time.*

Our fees are accordance with NZA guidelines. If you are insured with a Dutch medical insurance company we will declare our fees directly with your medical insurance company. We will send you a bill for any costs that we cannot claim from your medical insurance company or if you are not insured with a Dutch medical insurance company.

Please complete a separate copy of 3- 4 of this form for each member of your household.

W.D Boswinkel

Registration Form

|  |  |
| --- | --- |
| Surname |  |
| Street and house number |  |
| Post code |  |
| Telephone number |  |
| Male or Female | m / f |
| Date of birth |  |
| Initials + first name |  |
| Maiden name |  |
| Insurance Company + UZOVI nr. |  |
| Social Security number |  |
| Insurance policy number |  |
| Desired chemist |  |
| E-mail |  |
| Mobile telephone number |  |
| Nationality |  |
| Religion |  |
| Study discipline / profession |  |
| Marital status | single / living together / married / divorced/ widowed |
| Previous doctor (name, address) |  |
| Donor codicil | no / yes |
| Euthanasia passport | no / yes since: |

* Do you have one or more of the following conditions and for how long?

O Diabetes

O Lung disease: asthma, copd or other ..........................................................

O High blood pressure

O High cholesterol

O Cardiovascular disease, namely ...............................................

O Psychiatric illness, namely ...............................................

O Ailments of the liver or intestines, namely ...............................................

O Chronic symptoms of the joints

O Sexually transmitted disease, namely ................................................

O Kidney disease

O Thyroid problems

O Other illness, namely ………......................................

* Which illnesses are in the family and who suffers from them (father /mother /brother /sister /grandparent on mother’s side etc.)?

O Diabetes by whom:……………………………………………

O High Blood pressure by whom:………………….…………………….…

O High cholesterol by whom:…………………………………….……

O Cardiovascular disease by whom:…………………………………………

O Stroke or brain hemorrhage by whom: …………………………………………

O lung disease: asthma/copd by whom:………………………………….

O Kidney disease by whom: …………………………………

O Psychiatric illness by whom:…..………………………………

O Cancer + type of cancer by whom: …………………………………

* Are you hypersensitive (allergic)?

O No

O yes, for medicine, namely..................................................

Specific food or drink, namely..................................................

Other, namely …..............................................

* Do you smoke?

O No

O Yes, ...... cigarettes/shag/cigar/pipe per day

O Stopped since: ………………….

* Have you ever had an operation?

O No

O Yes, please list any operations in the following table

|  |  |
| --- | --- |
| Date of operation | Operation |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

* Do you currently take any medicine?

O No

O Yes, Please list the medicines in the following table

|  |  |  |
| --- | --- | --- |
| Medicine name | Strength | Dosage |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

* Please mention here anything that you think that your doctor should be aware of

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

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

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

Signature Date