Medisch Centrum de Pionier
Hugo de Vriesstraat 17
2152 CT Nieuw Vennep
Tel: 0252-245500

- B. Berndsen / D.Hertog
- C.T. de Ruijter
- F. Slabbekoorn

In te vullen door de assistente:
Formulier volledig: ja/nee
ID check/BSN: ja/nee
Oude huisarts inlichten: ja/nee
Op-tin: ja/nee
ION: ja/nee
COV check: ja/nee
MGN mail: ja/nee

Registrationform

(return in person with a valid ID)

***cross out what is not applicable**

Personal information

Surname / Maiden name	/ M/F*
Initials / First name	/
Date of birth	
Address / Number	/
Zipcode / City	/
Telephone numbers	/
Social situation	Single /Living together/ Married/ Family/One parent family/ Divorced
Profession	
If divorced and you have children, who has the family guardinship?	Father/ Mother/ Both * →Please attach a copy from the judicial sentence
Email	

Insurance name	
Insurance number	
BSN number	

Information previous general practitioner

(Please unsubscribe at your previous general practitioner. Please bring in person your medical file to us or by special delivery.)

Name	
City	
Fax number	

Medical information

	Do you have a medical history with one of the following diseases? If yes, since when?	Are these diseases present in your family?
Hypertension/bloodpressure		
Cardio and vascular disease		
Pulmonary disease		
Kidney disease		
Stomach or bowel disease		
Diabetes		
Regular bladder infections		
Cancer		

Psychiatric diseases		

Allergic reactions for medication?	Yes/ No*	If yes,please specify?
Allergic reactions for iodine ?	Yes/ No*	
Food intolerances?	Yes/ No*	If yes, please specify?

Did you ever have a surgical intervention?

Previous hospital admissions + treatments:

Do you take medication? If yes, please specify:

1.	4.
2.	5.
3.	6.

Did you receive the annual flu-vacination? Yes / No* _____
Do you smoke? (If yes, what do you smoke and how many daily?) Yes/ No* _____
Do you drink alcohol? (If yes, what do you drink and how many glasses a day?) Yes/ No*_____
Do you (sometimes) use drugs? (If yes, what do you use and how often?) Yes/ No* _____

Is there anything else important for us to know?

For females

Do you have a IUD? Yes/ No* If yes, since?_____
Are you pregnant? Yes/No* If yes, the first day of the last Menstruation:_____

Date:

Signature:

To be completed by the assistant:

Inleverdatum:	
Toegewezen huisarts:	Apotheek:
Familie hier al patiënt? Ja / Nee, Zo ja, bij wie?	
Waarmee gelegitimeerd?	