GP Practice
Baecke & Nobel

Dear Sir / Madam,

You want to register as a patient at **GP Practice Baecke & Nobel**.

Please fill in the attached form and return to us **personally**, together with a **copy of your ID and a copy of the care insurance or -card**.

Without these copies, we **can't** process your registration.

We would like to have these following documents, completed and returned to us:

1. New patient registration form
2. Medical history form
3. Letter for your previous GP
4. Consent Form to the LSP
5. Copy of ID
6. Copy care insurance policy or -card

Would you also immediately request your medical records from your previous doctor and let them send to us digitally?

Your registration with your previous family doctor will be deregistered upon registration in our GP Practice, since Health Insurance Care does not allow patients to be registered at more than one family doctor at the same time.

We claim the costs for medical care according directly to your health insurance rates fixed by the NZA. The insurer settles with you any excess. For costs that we can't collect from your insurance company, you get yourself a bill.

Kind regards,

GP Practice Baecke & Nobel

Beukenlaan 4a-III

2612 VC Delft

GP Practice
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NEW PATIENT REGISTRATION FORM

Surname:	Mr./ Mrs. / Ms. / Miss ……
Maiden name:	……
First names (+ forename):	……
Date of birth:	……
BSN (citizen service No):	……
Marital status:	single / living together / married / divorced
Street + number:	……
Postal code + city:	……
Phone number(s):	……
E-mailadres:	……
Insurance Company:	……
Insurance number:	……
Preferred pharmacy:	……
Previous physicians name + city:	……
Religion:	……
Nationalitity:	……
Education / profession:	……
Work:	working / unemployed/ disabled/ retired / other: ……
Donorcard:	Yes / No
Living will / euthanasia:	Yes / No

Delft, …… (date) Signature: ……

GP Practice
Baecke & Nobel

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MEDICAL HISTORY FORM

We would be appreciated if you could fill in this form concerning your health. If your household consists of more than one person, each person should complete the form separately.

Are you currently being treated or have been treated for in the past for diabetes, asthma / COPD, hypertension, high cholesterol, heart disease, mental disorders, gastrointestinal and / or liver disease, joint problems, kidney disease or thyroid disorders?

……
……

Are you currently treated by a specialist? If yes, which specialist and hospital (+ City).

……

……

……

Have you ever been hospitalized or admitted to surgery? If yes, what for and when.

……

Do you currently use medications? If yes, please list name of the drug, strenght and dosage.

……
……
……

Are you allergic to penicilline or any other drug (substance)? If yes, which medicine or (substance) drug?

……

Do you smoke?

- No, I never have smoked.
- Yes, ……cigarettes per day
- Yes, formerly smoked, but quit smoking as from: ……

Are there (hereditary) conditions in the family? If yes, which ilnesses and which family member (including parents and children)?

* Diabetes	Family member:
* Lung problems (Asthma / COPD)	Family member:
* High blood pressure	Family member:

GP Practice
Baecke & Nobel

* High Cholesterol	Family member:
* heart and vascular disease	Family member:
* Stroke or brain hemorrhage	Family member:
* Mental disorders	Family member:
* Kidney diseases	Family member:
* Cancer and cancer type	Family member:
* Gastrointestinal and / or hepatic impairment	Family member:
* joint pain	Family member:
* Thyroid Disorders	Family member:

If there is any other (serious) illness, important for the familiy doctor to know, please list.

……

……

……

Thank you in advance for completing these forms.

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REQUEST MEDICAL RECORD PREVIOUS PHYSICIAN Faxnummer : ……..

Geachte dokter ……

Hierbij bericht ik u van het feit, dat ik mij per …….. (datum) heb laten inschrijven in de praktijk van:

Huisartsenpraktijk Baecke & Nobel
Beukenlaan 4a-III 2612 VC Delft
Tel. 015 - 2131313
Email: info@huisartsenpraktijkbaecke-nobel.nl

Praktijk AGB: 1059202

U wordt vriendelijk verzocht mij uit te schrijven en het medisch dossier aan deze huisarts over te dragen.

>>De nieuwe huisarts ontvangt het medisch dossier graag in elektronische vorm<<

Via ZORG FILE TRANSFER kunt u het medische dossier per beveiligd e-mail als bijlage (middels EDI bestand of pdf) versturen naar: Huisartsenpraktijk Baecke & Nobel t.a.v. mevrouw S.J.M. Nobel-Tjokroatmodjo, huisarts

Postbusnummer / Zorgmailadres: 500102074@lms.lifeline.nl

Datum:

Handtekening:

Naam: ----------

Adres: ----------

Geboortedatum: ----------

BSN: ----------

Dit verzoek geldt ook voor de volgende personen:

Voorletters	Achternaam	Geboortedatum	M / V	BSN/Sofinummer

GP Practice
Baecke & Nobel

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Permission form

Your medical data available through the LSP

I do / do not authorize the following healthcare provider(s) below to make my data available through the LSP. I have read all the information contained in the 'Your medical data available through the LSP (National Exchange Point)' brochure.

GP or pharmacy details

Which healthcare provider does te form concern (provider 1)?	☐ my GP ☐ my pharmacy	☐ YES ☐ NO
Name:		
Address:		
Postcode and town:		

Which other healthcare provider does te form concern (provider 2)?	☐ my GP ☐ my pharmacy	☐ YES ☐ NO
Name:		
Address:		
Postcode and town:		

My details

Complete the below details. **Do not forget to sign the form.**

Family name:	Initials:	☐ M ☐ F
Address:		
Postcode and town:		
Date of birth:		
Signature:	Date:	

Do you wish to give permission with respect to your children?

- For children up to age 12: as a parent or guardian, you have to give your permission. Please use this form.
- For children aged 12 to 16 who wish to give their permission: both the parent or guardian and the child need to sign the form.
- Children aged 16 and over need to give permission themselves and complete a separate form.

Details of my children

Complete the below details of the children with respect to whom you wish to give permission. Do not forget to provide your own signature. Do you have more than two children? Please complete a new permission form.

Personal and family name:		☐ M ☐ F
Date of birth:		Provider 1: ☐ YES ☐ NO
Signature child:		Provider 2: ☐ YES ☐ NO

Personal and family name:		☐ M ☐ F
Date of birth:		Provider 1: ☐ YES ☐ NO
Signature child:		Provider 2: ☐ YES ☐ NO

Date:	Signature parent of guardian:

Submit this form to (one of) the healthcare provider(s) to whom your permission concerns.

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GP Practice
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