## **Application form**

**De Doc general practitioners** P.a. Boomsluiterskade 299

P.a. Boomsluiterskade 299 2511 VJ DEN HAAG Tel 070-3824777



Date:

Personal data								
Name								
Initials					Sex		☐ Male	☐ Female
Street					Numbe	er		
ZIP code			Residence					
Date of birth								
Place of birth				Cour	ntry of bi	rth		
BSN number						·		
Phone number at home								
Mobile phone number								
Phone number at work								
E-mail								
Marital status	☐ Single		☐ Married or li	ving to	gether	□ W	idow(er)	
Students								
Studentnumber								
Name educational	institution							
Expected date of generated date of recountry		Mont	th:	Ye	ar:			

Data previous GP				
Name:				
Address:				
Phone number:				
Data health care insu	rance			
Company name:			Policy number:	
Uzovi number:1				
Data pharmacy				
At which pharmacy ar	e you inscribed? (Name)			
Address				
Share medical inform	nation			
	necessary to share medical in			
you permission to shar	re this necessary information	n via the LSP.	(For more inform	ation see the leaflet:
Your medical data ava	ilable through the LSP (Nat	ional Exchang	ge Point)Only if	you agree)
O Yes I give my pern	nission	o No. I do	n't give permission	on.

The code of your health insurance, 4 numbers. You can find the code on your insurance card.

Are you suffering from any chronical diseases?	Are you suffering from any chronical diseases?	Are you suffering from any chronical diseases?	Information about your health			
Are you being treated by a specialist?	Are you being treated by a specialist?	Are you being treated by a specialist?		?	□ No □ Y	l'es
If yes, which department:  Are you using any medication?	If yes, which department:  Are you using any medication?	If yes, which department:  Are you using any medication?	If yes, which one(s)?			
If yes, which one(s):  Do you have any allergies?	If yes, which one(s):  Do you have any allergies?	If yes, which one(s):  Do you have any allergies?		□ No □ Yes		
If yes, to what:  Do you smoke?	If yes, to what:  Do you smoke?	If yes, to what:  Do you smoke?		□ No □ Yes		
Do you drink any alcohol?	Do you drink any alcohol?	Do you drink any alcohol?		□ No □ Yes		
Are there any illnesses in your family (brothers and sisters, (grand) parents?  No Yes  If so, which one(s):    For women only:	Are there any illnesses in your family (brothers and sisters, (grand) parents?  No Yes  If so, which one(s):  For women only: Date of last cervical smear: Date of last mammography (photo of breasts):  Result:  Children  Do you have children No Yes at home?  If yes, please mention: first name, initials, family name and date of birth.  N.b. If you want to sign up your children in our office, please fill in a separate form for each of them.  4.	Are there any illnesses in your family (brothers and sisters, (grand) parents? No Yes  If so, which one(s):    For women only:	Do you drink any alcohol? ☐ No	·	☐ Yes Hov	v much:
Date of last cervical smear: Date of last mammography (photo of breasts):  Children  Do you have children  No Yes at home?  If yes, please mention: first name, initials, family name and date of birth.  1.  N.b. 1.  If you want to sign up your children in our office, please fill in a separate form for each of them.	Date of last cervical smear:  Date of last mammography (photo of breasts):  Result:  Children  Do you have children	Date of last cervical smear: Date of last mammography (photo of breasts):  Children  Do you have children	Are there any illnesses in your family (brothers	•		
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Below you can note further information of your health, like a severe illness, accident or event. You also reliscuss this information with your doctor. Feel free to make an introductory meeting.			Do you have children at home?  If yes, please mention: first name, initials, family 1.  2.  3.  4.  Further information Below you can note further information of your	ily name and date	vere illness, a	If you want to sign up your children in our office, please fill in a separate form for each of them.
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We request you to inform your previous general practitioner that you have changed to our medical centre and to ask for your medical file. After we have received your medical file, you are registered as a patient at our medical center.