**Application form**

**Huisartsenpraktijk Pootstraat**

Doctors:

Mw. H. Rick

Mw. M. Ham

Mw. L. de Jong

Pootstraat 174 B

2613 PN Delft

015-2144652

www.happootstraat.nl

Thank you for signing up for our GP practice. Note that we only subscribe new patients who live close to our general practice. Only L. de Jong accepts patients.

Please check with our assistants first if your address is included in our service area first before you continue reading. If you already have a Dutch GP in Delft, it is NOT possible to register here.

For registration we need you to fill out three forms:

Application form A: includes general information about you and your relatives.

Application form B: includes questions about your medical history. Please fill out a separate form B for every family member.

Application form C: includes your agreement and signature for online services, sharing medical information with emergency services (spoedpost HAPSchievliet) and pharmacy. You thereby have to agree for sending your medical history from a previous Dutch general practice, if available.

All family members aged over 16 need to sign.

Online services: When you’ve been registered, you will receive a digital invitation for our online environment. This gives the opportunity to access our online services including email consultation.

Every family member needs to register with their own e-mail address.

For complete registration you need to submit the application form and show us your ID (passport or driver’s license) and insurance card.

Yours sincerely,

H. Rick, huisarts

M. Ham, huisarts

L. de Jong huisarts

Application form A

Main insured person

|  |
| --- |
| Initials & name: M/F |
| Surname: |
| Date of birth: |
| Adress: |
| Postal code: |
| Phone number(s) |
| Health care provider: UZOVI code: |
| Insurance number: |
| Citizen service number (BSN): |
| ID: drivers license/ passport/ ID card no: |
| Mailadres: @ |

Preferred pharmacy in Delft:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Required!)

Family members:

**In case of divorce, we need to know if parents both have parental authority: Yes/ No**

|  |
| --- |
| Initials & name: M/F |
| Surname: |
| Date of birth: |
| Phone number(s) |
| Health care provider: UZOVI code: |
| Insurance number: |
| Citizen service number (BSN): |
| ID: drivers license/ passport/ ID card no: |
| Mailadress: @ |

|  |
| --- |
| Initials & name: M/F |
| Surname: |
| Date of birth: |
| Phone number(s) |
| Health care provider: UZOVI code: |
| Insurance number: |
| Citizen service number (BSN): |
| ID: drivers license/ passport/ ID card no: |
| Mailadress: @ |

|  |
| --- |
| Initials & name: M/F |
| Surname: |
| Date of birth: |
| Phone number(s) |
| Health care provider: UZOVI code: |
| Insurance number: |
| Citizen service number (BSN): |
| ID: drivers license/ passport/ ID card no: |
| Mailadress: @ |

|  |
| --- |
| Initials & name: M/F |
| Surname: |
| Date of birth: |
| Phone number(s) |
| Health care provider: UZOVI code: |
| Insurance number: |
| Citizen service number (BSN): |
| ID: drivers license/ passport/ ID card no: |
| Mailadress: @ |

**Application form B** registration date:

**Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Profession or study:

|  |
| --- |
|  |

Do you suffer from chronic diseases (high bloodpressure, diabetes, heart problems etc.)

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| --- |
|  |

Do you have any major medical history (for example, operations)? If so, please also give dates,

|  |
| --- |
|  |

Do you smoke?

|  |
| --- |
| Yes/ no/ in the past |

Have you received vaccination for influenza in the past?

|  |
| --- |
| Yes/ no |

 Do you use medication? (please give name, dose and dosage)

|  |
| --- |
|  |

Do you suffer from any allergies?

|  |
| --- |
|  |

Hereditary illnesses?

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| --- |
|  |

Other important information?

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| --- |
|  |

**Application form C**

**( Note that we need this declaration form from every family member aged above 16! )**

I, name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

hereby confirm that I wish to be registered as a new patient of Huisartsenpraktijk Pootstraat,  Delft, L. de Jong, GP.

I agree that a copy of this form can be used to request for correction of insurance declarations sent to the insurance company.

I agree to registration for online services using my e-mail address.

I agree to share my medical history with emergency services (huisartsenpost) and

hospital. ( [www.ikgeeftoestemming.nl](http://www.ikgeeftoestemming.nl) )

* Yes, I agree
* No, I decline

I agree that my medical file will be reclaimed from my previous (Dutch) general practitioner.

The medical file can be sent electronically to Huisartsenpraktijk Pootstraat (AGB 01009033)

*Family members aged under 16*

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| --- | --- |
| Naam | Geboortedatum |
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*Information previous general practitioner*

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| --- |
| Name office/doctor: |
| Phone number: |
| Address: |
| City: |
| **MAIL ADDRESS** (Please check this for us! Obligate!) |
| **Date:                                                       Your signature:** |