J.D. Kippersluis o
N.A.D. Geurts o
M.A.M. Mulder o

Huisartsen
Weerdsingel wz 40
3513 BD Utrecht
Telefoon: 030-2313477
Fax: 030-2342107

Patient data

Registration date: _____

Last name: _____ M/F:____

Initials: _____ Firstname: _____

Marital status*: Married / Single / Widow / Widower/ Living together:

*Living together with:*___ _____*Date of birth:*_____ _____

Date of birth: _____

Place of birth: _____

Address : _____

Zip code: _____

Email address: _____

Phone number : _____ Preffered pharmacy:_____

Insurance: _____ Uzovicode: _____

Insurance number: _____

Identity*: ID-card / passport / driving license / different: _____

Identification number: _____ BSN Number:_____

Previous general practitioner: _____

Address previous general practitioner: _____

Place, zip code previous general practitioner: _____

Phone no/fax no general practitioner: Phone: _____ Fax. _____

Permission for LSP YES/NO

Signature Patient**: _____

* encircle all that apply

** I hereby give permission to request my medical records at my previous General Practitioner

Medical information

Name:_____ Date of Birth: _____

Diseases:		Since:	Check up:
Diabetes type 1 / 2*	yes / no	Year:_____	Specialist / general practitioner
Asthma/COPD	yes / no	Year:_____	Specialist / general practitioner
High blood pressure:	yes / no	Year:_____	Specialist / general practitioner
Cardiovascular disease	yes / no	Year:_____	Specialist / general practitioner

If yes, please state here: _____

Other chronical diseases:

_____

_____

Operations, what year?

_____

_____

Medication list:

Name:	Dosage:	Use:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Allergies:

Allergy/hypersensitivity (for medication or other) : Yes / no

Name:	Complaints:
_____	_____
_____	_____

Other:_____

_____

Signature Patient**: _____

* encircle all that apply

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