

Registration form

Please bring your valid identity document!

Personal information

*Circle what's applicable

| | |
|------------------------|---|
| Last name/Maiden Name | / |
| Home address | |
| City & zip code | |
| Home phone/ Cell Phone | / |
| E-mail | |
| Living situation | Alone / living together / married / single parent / family* |

| | | |
|------------------------------|-------------------|--|
| Gender at birth ¹ | Male / Female* | |
| If applicable: | Gender identity | |
| | Preferred pronoun | |
| Date of birth | | |
| First name / Middle name | | |

¹For medical reasons, it is important that we record your gender at birth in your file. Unfortunately, our system still has limitations regarding the registration of gender identity.

| | |
|------------|--|
| Occupation | |
| Religion | |

| | |
|------------------------------------|--|
| Name of insurance/Insurance number | |
|------------------------------------|--|

For children

| | |
|------------|------|
| Guardian 1 | tel: |
| Guardian 2 | tel: |

Information previous family doctor

| | |
|-------------|--|
| Name & City | |
|-------------|--|

Medical history

| | Do you have the following illness? If so, since what year? | Has any blood relative had the following illness? |
|----------------------------------|---|---|
| High blood pressure | | |
| Heart disease/ heart attack | | |
| Lung disease | | |
| Kidney disease | | |
| Stomach/liver/intestinal disease | | |
| Diabetes Mellitus | | |
| Recurrent urinary infection | | |
| Cancer | | |
| Psychiatric illness | | |

| |
|--|
| Have you ever been operated or admitted to the hospital? If yes, please provide the reason and date. |
| |

See opposite side >>

Continued medical history

Are you currently being treated by a specialist? If yes, please provide the reason and name and/or type of specialist.

Are you allergic to medication/antibiotics or iodine? If yes, which one and what kind of reaction?

Yes / No*

Do you take medication regularly? If yes, please provide the name and dosage.

| | | |
|---|---|---|
| 1 | 3 | 5 |
| 2 | 4 | 6 |

Do you have a medical reason to have the flu shot?

Yes / No*

Do you smoke? If yes, what and how much per day?

Yes / No* :

Do you drink alcohol? If yes, how many drinks per week?

Yes / No* :

Do you use drugs? If yes, which one and how often per week/month?

Yes / No* :

Height:

Weight:

Is there anything else that you think we should be aware of?

For women

Have you ever had a pap smear? If yes, when and what was the result?

Yes / No* :

Do you have an IUD? Other birth control?

Yes / No*

Please hand this form directly to the medical assistant.

To be completed by the medical assistant

Inleverdatum

Assistente

Huisarts

Apotheek

Burger Service Nummer

Aangemeld bij ION

Yes / No*

MgN?

Yes / No*

Aard en nummer identiteitsdocument

Partner hier al patiënt

Yes / No*

**Zo ja, naam en
geboortedatum:**

May your email be used for client consultation?

Yes / No*

May your email be used for referral appointments?

Yes / No*

Sign-up for LSP?

Yes / No*

Sign-up for newsletter?

Yes / No*

For more information on LSP, check our website or ask the assistant.