

## 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 <sup>1</sup>	Male / Female*	
If applicable:	Gender identity	
	Preferred pronoun	
Date of birth		
First name / Middle name		

<sup>1</sup>For 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.