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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Inschrijfformulier**  **Huisartsen Heikens & Broeder**  3434 EW Nieuwegein  Tel 030-6061160  [www.zorgpleinzuid/heikensbroeder](http://www.zorgpleinzuid/heikensbroeder)  info.heikensbroeder@zorgpleinzuid.nl | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Voorletters:**  *Initials* | |  | | **Achternaam:**  *Surname* | | | |  | | | | | | | | | |
| **Roepnaam:**  *First name* | |  | | **Geboortedatum:**  *Date of birth* | | | |  | | | | | | | | | |
| **Adres:**  *Street address* | |  | | **Geslacht:**  *Sex* | | | | Man  *Male* | | | | *□* | | Vrouw  *Female* | | | *□* |
| **Postcode:**  *Postal code* | |  | | **Woonplaats:**  *Place of residence* | | | |  | | | | | | | | | |
| **Telefoonnummer:**  *Home phone* | |  | | **E-mailadres:**  *E-mail address* | | | |  | | | | | | | | | |
| **Mobiel nummer:**  *Mobile phone* | |  | | **Burgerlijke staat:**  *Marital status* | | | | Gehuwd *Married* | | | | *□* | | Alleenstaand *Single* | | | *□* |
| **Geboorteplaats:**  *Place of birth* | |  | | Samenwonend *Partnership* | | | | *□* | | Gescheiden D*ivorced* | | | *□* |
| **BSN:**  *Social Security Nr.* | |  | | Weduwe  *Widow* | | | | *□* | | Weduwnaar  *Widower* | | | *□* |
| **Apotheek:**  Pharmacy | |  | |  | | | |  | | | |  | |  | | |  |
| **Zorgverzekeraar:**  *Health insurer* | |  | | **Polisnummer:**  *Insurance number* | | | |  | | | | | | | | | |
| **Vorige huisarts:**  *Previous GP* | |  | | **Adres:**  *Street address* | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Geeft u toestemming voor het delen van uw medische gegevens met andere zorgverleners? | | | | | | | | | | | | | Ja | | *□* | Nee | *□* |
| Wilt u via de app in uw dossier en medicatie kunnen bestellen? | | | | | | | | | | | | | Ja | | *□* | Nee | *□* |
| Akkoord opvragen medische dossier oude huisarts? | | | | | | | | | | | | | | Ja | | *□* | Nee | *□* |
| **Medische voorgeschiedenis**/ *Medical history* | | | | | | | | | | | | | | | | | |
| **Bent u bekend met een chronische aandoening? Zo ja, welke**? *Are you diagnosed with any chronic illnesses? If yes, which one(s)?* | | | | |  | | | | | | | | | | | | |
| **Heeft u ooit een operatie ondergaan? Zo ja, welke?** *Have you ever had surgery? If yes, which one(s)?* | | | | |  | | | | | | | | | | | | |
| **Gebruikt u medicatie? Zo ja, welke?** *Do you use any medication? If yes, which one(s)?* | | | | |  | | | | | | | | | | | | |
| **Heeft u ooit een griepvaccinatie gehad?** *Have you ever received an anti flu vaccine?* | | | | | Ja  *Yes* | | *□* | | Nee  *No* | *□* |  | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Datum:**  *Date* |  | | **Hantekening:**  *Signature* | | |  | | | | | | | | | | | |

