Huisartsenpraktijk Verwielstraat
Burg. Verwielstraat 2H
5141 BD Waalwijk

T 0416- 332 331
E patientverwielstraat@ezorg.nl
W www.huisartsenpraktijkverwielstraat.nl

Dr. D.A.C. Rutten
Dr. H.H.C. van Bakel
Dr. B.F.M. Damen

Registration Huisartsenpraktijk Verwielstraat

We are obliged to check your ID when you register with our practice.
Please bring a valid ID with you when you hand in this form.

Last name .....

Initials ..... First name .....

Date of birth ..... BSN .....

Address .....

Zipcode ..... City .....

Phone number ..... Mobile .....

Emailaddress .....

First contact .....

Phone number .....

Are you moving in or do you live together with someone who is a patient with us? Yes / No

If so, please write down their name and date of birth .....

Pharmacy of your choice

☐ Apotheek De Langstraat (Burgemeester Verwielstraat 2G)

☐ Apotheek Olympia (De Coubertinlaan 10c)

☐ Apotheek De Ducdalf (Blyde Incomstelaan 9)

☐ Apotheek Driessen (Koetshuislaan 603)

Do you give permission to share your medical record with the medical emergency post and the pharmacist. Yes / No

I hereby give permission to send a request to my previous GP to get my medical record:

Signature .....

Name last GP .....

Address..... City.....

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Medical history

Are you familiar with one of the conditions below?

☐ Diabetes Mellitus
☐ Epilepsy
☐ Hypertension / High bloodpressure
☐ Heart and/or vascular disease
☐ Lung disease (COPD / Asthma / Chronic bronchitis / TB)
☐ Otherwise, namely ……

Are you being treated by a specialist? Yes / No

If so, for what purpose and which one……

……

Have you ever had an operation? Yes / No

If so, when and which ……

……

Are you familiar with an allergy? Yes / No

If so, for what ……

……

Are you taking any medications? Yes / No

Name:		**Dose:**	Use:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			