

# Registration form for General Practice Strijp-S



HUISARTSENPRAKTIJK  
**STRIJP-S**

**Note 1:** You can register if you live within the postal code areas 5616, 5617, 5621, and 5651.

**Note 2:** Identification with a passport, driver's license, or identity card is legally required at registration. This must be done during your first visit to the practice.

**Note 3:** If you wish to register a family member, a separate form must be completed for each individual.

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## Registration with general practitioner

You will be automatically registered under the name of Dr. R. Falkenberg, but you can make your appointments with any general practitioner.

Date of registration at General Practice Strijp-S:

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## Registration Information

If you are registering yourself, please fill in your own details here. If you wish to register a family member with this form, please fill in the details of your family member here.

Initials:

Surname:

First Name:

Date of Birth:

Gender: ☐ Male ☐ Female

BSN (Dutch Social Security Number):

Email address:

Street name:

House number:

Postal code:

City:

Private phone number:

Work phone number:

Mobile phone number:

Living arrangement: ☐ Single ☐ Married ☐ Unmarried

☐ Living together ☐ Divorced ☐ Widowed

Insurance company:

Policy number:

Previous general practitioner:

Location of previous general practitioner:

Date of deregistration from previous general practitioner:

Previous pharmacy:

Would you like to register at the [Medi+Punt of Strijp-S](#) (where you can pick up your medication 24/7)?:

☐ Yes ☐ No

If other, pharmacy:

Type of identification document: ☐ Passport ☐ Identity card ☐ Driver's license

☐ ID card or passport from an EEA country ☐ Dutch residence permit

Identification document number:

### What is the reason for registration?

### Intolerances/allergies and other specifics

We would like to be sure that we have information available for every registered patient about intolerances/allergies and any other details. Would you like to fill it in below?

### Exchange of patient data

Do you give permission to GP practice Strijp-S to make your data available for consultation by other healthcare providers? For more information about this, please visit [www.volgezorg.nl](http://www.volgezorg.nl).

- ☐ Yes, I consent to my data being made available  
☐ No, I do not give permission for my data to be made available

### Moving your patient file

Please note: you must give your previous GP permission to send your patient file to our practice. If your previous GP has received your permission, he or she can send the file to our practice.

### Mijn Gezondheid.net

Your GP will offer you the patient portal [MijnGezondheid.net](http://MijnGezondheid.net). On this portal, you can access parts of your medical and medication file via a secure connection. You can also request repeat medication, view lab results, make an appointment online for a visit to the doctor, request an e-Consultation and consult reliable information about your conditions and medication. You can find more information about this on our website

<http://www.huisartsenpraktijkstrijps.nl>.

Please note that this portal is available for patients aged 16 and over. You can log in directly with your DigiD.

### Newsletter

If you would like to be the first to be informed of our healthcare news, you can register for this on our website [www.huisartsenpraktijkstrijps.nl](http://www.huisartsenpraktijkstrijps.nl).

## Signature

Date:

- *Are you (the patient who is registered) 16 years or older?*  
By entering your name below, you give the practice the assignment and permission to register you.

Name 1.

- *Are you (the patient who is registered) between 12 and 16 years old?*  
For family members aged 16 or younger where both parents have parental authority, a signature is required from both parents. By filling in the names of the patient to be registered and the parent(s)/guardian(s) below, you instruct and authorize the practice to register the patient.

Name 1: the patient who is registered with this form

Signature

Name 2: the name of parent/guardian 1

Signature

Name 3: the name of parent/guardian 2 (if applicable)

Signature

- *Are you (the patient being enrolled) under 12 years of age*  
For family members aged 16 or younger where both parents have parental authority, a signature is required from both parents. By filling in the names of the parent(s)/guardian(s) below, you instruct and authorize the practice to register the minor patient.

Name 1: the name of parent/guardian 1

Signature

Name 2: the name of parent/guardian 2 (if applicable)

Signature