Huisartsenpraktijk Amstelveen
Marne 130 b
1186 PJ Amstelveen
020- 6459559
www.huisartsenpraktijkamstelveen.nl

Registration form

We ask you to complete and sign this letter fully. We need this letter to inform your health care provider.

What we ask of you:

- the registration form fully to complete and sign
- a copy of your health insurance card and photo ID
- to inform your previous GP and to request your medical record (if possible)
- to make a choice whether or not to authorise the provision of your data to other healthcare providers

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To complete and check Assistant:

- Formulier volledig ingevuld
- Ingeschreven in HC
- COV check HC:
    - Verzekerd; schrijf in als actieve patiënt: vinkje bij inschrijving op naam
    - Niet verzekerd; (HC): schrijf patiënt in als NONI: haal vinkje weg bij patiënt-onderhoud-stamgegevens-extra gegevens-op naam ingeschreven
- ION aanmelden in HC
- WID controle: Kopie identiteitsbewijs en verzekeringspas
- Toestemming of geen toestemming Optin

Surname:…….. Firstname:……
Date of birth: (D,M,Y) …….. Gender: M/ F
Adress:…… Zipcode:……
Place of Residence:……..
Phone Number……..Mobile:……
E-mail adress:……
BSN number:……
Health Insurance:…… Policy number:……..
Pharmacy:……
Previous GP:……..
Allergies:……
Medication: ……
……
……
Disorders in the family:……..
Contact Person (ICE):……
Smoking: yes/ no.

If you have children under the age of 16 staying under your authority, you can fill in below. Children from 16 years have their own registration form. For My kids I give permission for LSP (see above) □ YES □ NO

Name	Date of birth	m/f	Health insurance	BSN number

□ Yes, I agree to provide my data (problem list and medication list) with the outpatient unit at Ziekenhuis Amstelland, by other health care providers of the outpatient unit of Ziekenhuis Amstelland, via the LSP, the care infrastructure with the VZVZ as a responsible party.	□ No, I do not agree to provide data.
□ Yes, I want to participate (only by email) in a research to improve the quality of care of patients. All results are anonymous (Qualiview).	□ No, I do not want to participate.
□ Yes, I want to make use of mijngezondheidsnet, so I can see my medical file, lab results, send emails and order medication online with my DigiD.	□ No, I do not want to make use of it.

Signature:……Date: (D,M,Y)……..