



Huisartsenpraktijk
Bos en Lommer

Registration Form

Family Name:		Burger Service Number (BSN):				
First Name:		Initials:		Gender:	M	F
Insurance Company:		Policy Number:				
Street:		House Number:				
Postcode:		City:				
Home Phone:		Mobile:				
E-mail:		Birthdate:				

Sign Up for LSP (Landelijk Schakelpunt)?	Yes	No
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Previous General Practitioner:		City:				
Registered Pharmacy:						
Marital Status:	Single	Living together	Married	Divorced	Widow or Widower	
Children:	Yes	No	Number living in the home:		Number living away:	
Type Work / Education?						
Native Country:		Languages Spoken:				

Do you exercise or sport?	Yes	No	Which sport/s?	
Do you smoke?	Yes	No	How many a day?	
Do you drink alcohol?	Yes	No	How many glasses a week?	
Do you use drugs?	Yes	No	Which drugs? How often?	

Allergies:	Yes	No	To?
Which medications do you use?			
Are you or have you been treated by a medical specialist?	Yes	No	For?
Are you, or have you been suffering from any other complaints or illnesses?	Yes	No	For?

Do you have a family history of:	Diabetes type 2:	Yes	No		Who:
	Heart Disease:	Yes	No	Type:	Who:
	Cancer:	Yes	No	Type:	Who:
	Other diseases:	Yes	No	Type:	Who:

Signature:

Date: