# Huisartsenpraktijk Cadier & Keer

## Registration form

When filling out the registration form, you give us permission to request your medical details from your former GP.

Last name: _____ Gender: Man / vrouw

Maiden name: _____

First name: _____ Initials: _____

Date of birth: ____/____/_____

Social Security number: _____

Address

Postal code: _____ House number: _____

Street name: _____ City: _____

Telephone numbers / email-addresses

Telephone number home address : _____

Mobile Number: _____

E-mail address: _____

Insurance

Insurance: _____

Insurance number: _____

Preferred pharmacy: _____

Name former GP: _ _____

Have you already deregistered with your former GP?_____

# Huisartsenpraktijk Cadier & Keer

Important medical history:

_____
_____
_____
_____

Important chronic medication:

- -
- -
- -
- -

Known allergies:

- -
- -
- -

Operations in the past / recent operations:

_____
_____
_____

Do you smoke? Yes / No

Chronic disorders / family burden?

_____
_____

Are you being treated by a Practitioner somatics for this? Yes / No

Do you agree that your medical data will also be visible at the GP Medical Post in Maastricht?

Yes / No

Date: Signature: