Dear Sir / Madam,

As a modern digital practice, we make use of several e-health solutions. We apply MijnGezondheid.net for this, a safe online patient portal where you can arrange your own health matters. Availability by phone is limited, online we are available 24/7.

If you are someone who prefers to arrange as much as possible digitally, instead of waiting on the phone, we are the ideal practice for you.

If you wish to register, please return the following documents to us:

1. This registration form, signed;
2. Copy of documentation of identity;
3. Copy of Health Insurance registration or card.

Please email to: **inschrijving@huisartsoverschie.nl**

You must also declare to agree with our house rules. If you can't or don't want to conform to these rules, we will not register you as a patient at our practice.

We will declare your healthcare costs according to the set tariffs by NZA, directly with your health insurance company. Your insurer will reimburse it, possibly with your deductible/excess. For healthcare costs not reimbursed by your insurance, you will receive the bill yourself.

Lastly, we recommend you to register register at a pharmacy in your neighbourhood. This can be done via the website of the pharmacy and only takes a few minutes.

Kind regards,

Huisartsenpraktijk Overschie

Rotterdamse Rijweg 130
3042 AS Rotterdam

Tel: 010 – 415 75 12
E: info@huisartsoverschie.nl

huisartsenpraktijk overschie.

HOUSE RULES

Your address

Due to the Health Insurance Act (Zorgverzekeringswet), we have an obligation to be able to be at your home within a certain timeframe in case of an emergency. As a result, in order to fulfill this obligation, your residence address must be in our care area. Until your address is not verified, we cannot register you as our patient.

→Register as soon as possible in the Municipal Personal Records Database (BRP).
→In case this isn't possible or the registration is taking too long to process, you can hand in a different kind of proof. For example, a rental agreement or municipal confirmation.
→Inform us of any address changes.

Conduct

Unfortunately, aggression in our practice is becoming increasingly common. We do not tolerate any physical or verbal aggression towards our staff. These incidents will be documented and discussed internally. We will then take the appropriate measures, in accordance with the guidelines of the Dutch Doctor Federation KNMG.

No-show policy

Appearing late or not appearing to your appointment can have various understandable reasons. Unexpected situations will naturally occur from time to time, and we fully comprehend this. In case of no show or late cancellation, we will unfortunately have to bill you.

→Cancel your appointments at least 24 hours in advance (on business days only).

Minors

Minors below the age of 16, must have at least one parent/caretaker registered as our patient. This parent/caretaker will sign for the minor. If there is a divorce with shared parental custody, both parents must sign for the registration of the child.

From the age of 16, they must sign themselves. From the age of 16, young people are allowed to decide on their own medical treatments. This is regulated in the WGBO, the Medical Treatment Agreement Act.

De-registration

If you change physician or move (abroad), please let us know. This way we can ensure your medical file doesn't get lost and we can maintain an update of our patient population. Furthermore, you are not allowed to be registered at more than one practice.

→ Inform us in case you move or register elsewhere.
→ Inform us if your contact details have changed (telephone number, e-mail).

On the following page you will sign to declare that you have read, understood and accepted the house rules above.

huisartsenpraktijk overschie.

REGISTRATION FORM

Surname/family name + Title : Mr/Mrs/Ms. ……..……..……..…..

Maiden name *(if applicable)* : ……..

Initials (+ first name) : ……

Date of birth : ……..

BSN (Citizen Service No.) : ……

Marital status : ……..

Home address (Street + No.) : ……..

Postal code + City : ……

Telephone number(s) : ……

E-mail address : ……..

Insurance company (+ Number) : ……..……

Preferred pharmacy : ……

You are advised to register with a pharmacy near to where you live. Your prescription will be sent automatically to the chosen pharmacy.

Previous physician : ……

Nationality : ……

Education or profession : ……

I authorize my physician to make my medical data available in the LSP to other healthcare providers, if this is necessary for my treatment. ☐ Yes ☐ No

→*For more information, please visit www.volgjezorg.nl*

YES, I would like to sign up to MijnGezondheid.net (online patient portal).

→ *Scheduling appointments, viewing your medical file, etc. This is mandatory from July 1st 2020.*

I want to share my medical records with my partner/parent(s)/family/administrator ☐ Yes ☐ No

Name/date of birth/BSN of authorized person: .....

(If revoking authorization, please contact our assistants)

Consent to the transfer of medical records *(if applicable)*

YES* I hereby give consent to my previous physician, doctor .....
to transfer my medical file digitally via ZorgFileTransfer to my new physician,
Huisartsenpraktijk Overschie, dokter V.T. Nguyen, praktijk AGB-code 01-009331

The undersigned hereby declares to have read, understood and accepted the house rules.

Rotterdam, ……(date) Signature of patient/guardian: .....

**If you do not consent to the transfer of your medical file to Huisartsenpraktijk Overschie, we unfortunately will be unable to provide adequate care; therefore we will not accept your registration.*

huisartsenpraktijk overschie.

MEDICAL HISTORY FORM

We would appreciate if you would fill out this form concerning your health.
Under the Medical Treatment Agreement Act (WGBO) the patient must fully inform the physician about their health.

Medical history that may be of importance (Current and past conditions)

Are you currently being treated by a specialist?
(Please list the specialist's name and the hospital)

Current medication (Please list the name of the drug, strength and dosage)

Allergies (Please list any allergies or adverse reactions you have had)

Medication or substance which caused the allergic reaction. What kind of reaction did you experience? When did this reaction first occur?

Do you smoke?
- ☐ No, I have never smoked.
- ☐ Yes,: …… cigarette(s) per day.
- ☐ Previously……. year(s)..... cigarette(s) per day. Quit as of : ……

Height:.....(cm) Weight:.....(kg) Waist circumference:.....(cm)

Are there any (hereditary) conditions in the family?

- ☐ Diabetes — Family member: .....
- ☐ High cholesterol — Family member: .....
- ☐ Heart and vascular disease — Family member: ..... From age: .....
- ☐ Thyroid disease — Family member: .....
- ☐ Cancer..... (what type?) — Family member: .....

Other medical information you wish to disclose:

Please send us a copy of your identification card together with this registration form.

Submit Form