Health centre and pharmacy registration form

Date received _____ by:_____

Registrations

Pharmacy sent _____ by:_____

Child health clinic (for children under four): _____ by: _____

ION _____ by: _____

Please fill in a separate form for each person aged sixteen or older.

You can include the names of any children under sixteen who are moving with you in the annex to this registration form.

Date of registration: _____

Name of health centre and/or pharmacy[1]: _____

Initials _____ Surname _____ m / f

Address: _____

Postcode: _____ Town/city: _____

Home phone number: _____ Mobile number: _____

Date of birth: _____ Citizen service number (BSN) _____

Health insurer: _____ Customer number: _____

Previous address: _____

Postcode and town/city: _____

Email address: _____

Consent to use of email address[2]

I hereby consent to the use of my email address for:

☐ sending the annual client satisfaction survey questionnaire.

Consent to use mobile number for SMS reminder service

☐ I hereby consent to the use of my mobile number for sending reminders of my appointments with the GP or nurse practitioner.[3]

Previous GP (if applicable)

Name: _____

Address: _____

Postcode: _____ Town/city _____

[1] Please strike out whichever options do not apply to you.

[2] Your consent, or lack thereof, will have no bearing on your treatment. You can revoke your consent at any time. Zorggroep Almere will not use your email address or mobile number for other purposes.

[3] The SMS reminder service results in fewer missed appointments. This means that you can see your GP or nurse practitioner sooner, as fewer consulting hours are booked unnecessarily.

Previous pharmacy (if applicable)

Name: _____

Address: _____

Postcode: _____ Town/city _____

I hereby declare:

- That my medical and pharmaceutical information may be requested from my previous GP and/or pharmacy and that those details may be included in my medical record with my new GP and pharmacy[4]
  ☐ YES GP ☐ NO GP
  ☐ YES pharmacy ☐ NO pharmacy

- MijnGezondheid.net is portal voor patients. Do you give the healthcare provider permission to register you for this?
  ☐ YES GP ☐ NO GP
  ☐ YES pharmacy ☐ NO pharmacy

- that I give permission to the GP and/or pharmacy[1] at _____ Health Centre to make my data available through the LSP[5]. I have read all the information in the "Making your medical data available through the Landelijke Schakelpunt (national switch point, LSP)" leaflet
  ☐ YES GP ☐ NO GP
  ☐ YES pharmacy ☐ NO pharmacy

Please sign this form after completing it and hand it in at the reception of your new health centre.
Remember to bring a valid proof of insurance and photo ID (driver's license, passport or ID card).
This is necessary to identify you and process your registration.
This also applies to any children under sixteen listed in the annex to this form.

If you are not insured, you must pay with cash or by card immediately after each consultation.
Please note: we only accept card payments in our pharmacies.

Signature(s) _____

Date: _____

[4] It is important that your GP and pharmacy have access to your current information to obtain an accurate picture of your medical status and ensure you receive the right care.

[5] It is important that your GP and pharmacy have access to your current information to obtain an accurate picture of your medical status and ensure you receive the right care. **This is only possible with your consent. You can revoke your consent at any time.**

Annex to the health centre and pharmacy registration form

Fill in the details of any children under sixteen moving with you:

Register at address:

Postcode: Town/city:

Child 1

Initials First name: Surname: M / F

Date of birth: Citizen service number (BSN):

Health insurer: Customer number:

Child 2

Initials First name: Surname: M / F

Date of birth: Citizen service number (BSN):

Health insurer: Customer number:

Child 3

Initials First name: Surname: M / F

Date of birth: Citizen service number (BSN):

Health insurer: Customer number:

By signing this annex, you declare that the details of the children moving with you have been filled in completely and correctly.

Parents/guardian/custodian:

Signature(s) Date:

If registering children under four:

By signing, you also grant permission for the child health record to be requested from the previous child health clinic. ☐ YES ☐ NO

Name of previous child health clinic:

If you are moving from outside Almere, please fill in the details of the previous child health clinic.

Address:

Postcode: Town/city:

Phone number: