

**Enrollment Form:**

Personal details:

First name:…………………......................................Surname:…………………..……

Initials:…………………………………………………………..….Gender: Male/Female

Date of birth:…………………….…………………………………

BSN nr:……………………….……………………………………....

Address:…………………..…………………………………………………NR…………………………..Zipcode:………………………...

City:………………………………………………………………………..Mail:……………………………....

Telnr private………………………....................................Telnr.work:………………………

Telnr GSM:……………………….................................................................................

Town of birth:……………………………………….

Profession:……………………………………………..

Name chemist:………………………………………..

Name and address previous family doctor: …………………………………………………..

……………………………………………………

…………………………………………………….

Married / living together / divorced / widow(er) / living alone.

With how many people are you living together? .....Partner ….Children

Insurance:

Insurance company:………………………………….

Insurance number:……………………………………

Identification number……………………………………………………………………………….

* Passport
* Dutch identiticard
* Driverslicense
* Aliendocument **P.T.O.**

Medical History:

Did you ever have any of the following complaints:

0 Diabetes Mellitus

0 Lung problems

0 Heart diseases

0 Mental disorders

0 Eating disorders

0 Gastrointestinal diseases

0 Rheumatic diseases

0 Thyroid problems

0 Other serious diseases: …………………………………………………….

Do you use medication?

Do you visit a specialist for medical reasons?

Did you ever have an accident or did you ever have an operation?

Have you ever been a victim of violence?

Do you suffer from any allergic reactions? Which ones?

Do you smoke?

Do you use drugs?

Did you have the influenza vaccination? If so, why and when?

Family medical history:

0 Diabetes Mellitus

0 Lung problems

0 Heart diseases

0 Mental disorder

0 Hypertension

0 Stroke

0 Rheumatic diseases

0 Cancer, location…………….

Date: Signature