ONLINE INTERNATIONAL PATIENT INFORMATION FORM

(This file content is special to patient and will never be shared to third persons according to our privacy policy)

Date :...../ ...../20 .....

Patient's Surname/Name	Passport/Identity No:
Date of Birth	Blood type:
Profession	Gender: O Female O Male
Home Address	
	City:
	Country:

Telephone: Home: ..... Work:..... Cell phone:.....

Fax :.....E-mail: .....

A relative that we can contact;

Surname/Name Telephone No:

(If exist, covering Dental treatments) Name of Private Health Insurance :.....

Policy no : ..... Policy End Date:.....

Your complaint (reason of your admission):.....

Why did you prefer Dentistanbul in your first visit? (Select all appropriate options)

❍ Upon the recommendation of a friend or someone close to me

❍ Through advertisement/Publicity of Dentistanbul

- ❍ Internet publicity
- ❍ Dentistanbul web site
- ❍ Newspaper advertisements / news
- ❍ Twitter
- ❍ TV Programs
- ❍ Newsletters
- ❍ SMS
- ❍ Facebook

❍ Contractual institutions / insurance company agreement / Travel Agent (please specify)

❍ Other (please specify)

Please answer the questions in the back page, ask your doctor if you have further questions. Your answers to these questions are important for your health and treatment. Thank you…

Please select the appropriate ones. (The unselected will be accepted as (N: No)]

CARDIOVASCULAR DISEASES

Heart Attack (infarction)	☐ Y	☐ N
Angina pectoris or chest pain	☐ Y	☐ N
High blood pressure	☐ Y	☐ N
Low blood pressure	☐ Y	☐ N
Cardiac murmur	☐ Y	☐ N
Cardiac or aortic valve disease	☐ Y	☐ N
Rheumatic fever [Heart rheumatism]	☐ Y	☐ N
Hole in the heart	☐ Y	☐ N
Rhythm disorder or palpitations	☐ Y	☐ N
Pacemaker	☐ Y	☐ N
Heart surgery or transplant	☐ Y	☐ N
Other cardiac diseases	☐ Y	☐ N
Paralysis (stroke)	☐ Y	☐ N
Aneurysm	☐ Y	☐ N

BLOOD DISEASES

Hemophilia or coagulation disorder	☐ Y	☐ N
Anemia	☐ Y	☐ N
Blood transfusion	☐ Y	☐ N
Leukemia	☐ Y	☐ N
Prolonged bleeding	☐ Y	☐ N

NEUROLOGICAL AND SENSORY DISORDERS

Glaucoma (Eye Pressure)	☐ Y	☐ N
Ear pain or ringing	☐ Y	☐ N
Psychiatric treatment	☐ Y	☐ N
Migraine, severe headache	☐ Y	☐ N
Dizziness and fainting	☐ Y	☐ N
Down syndrome	☐ Y	☐ N

DIGESTIVE SYSTEM

Ulcer	☐ Y	☐ N
Colitis	☐ Y	☐ N
Crohn disease	☐ Y	☐ N
Diverticulitis	☐ Y	☐ N
Hepatitis (A, B, C]	☐ Y	☐ N
Jaundice (icterus, hyperbilirubinemia)	☐ Y	☐ N
Cirrhosis of the liver	☐ Y	☐ N
Liver transplant	☐ Y	☐ N

RESPIRATORY SYSTEM

Sinusitis	☐ Y	☐ N
Allergic asthma	☐ Y	☐ N
Emphysema	☐ Y	☐ N
Chronic cough	☐ Y	☐ N
Tuberculosis (TBC)	☐ Y	☐ N
Bronchitis	☐ Y	☐ N
Bad breath	☐ Y	☐ N

MUSCULOSKELETAL AND SKIN SYSTEM

Allergy to Latex (Rubber)	☐ Y	☐ N
Skin rashes	☐ Y	☐ N
Night sweats	☐ Y	☐ N
Moles changing shapes	☐ Y	☐ N
Joint inflammation	☐ Y	☐ N
Osteoporosis	☐ Y	☐ N
Swelling and herpes on the skin	☐ Y	☐ N
Other allergies (food etc.)	☐ Y	☐ N

HORMONAL DISEASES

Diabetes	☐ Y	☐ N
Insulin addiction	☐ Y	☐ N
Thyroid diseases (Goitre etc.)	☐ Y	☐ N

KIDNEY DISEASES AND SEXUALLY TRANSMITTED DISEASES

Dialysis	☐ Y	☐ N
Böbrek nakli	☐ Y	☐ N
Sexually transmitted diseases (syphilis, gonorrhea, chlamydia, herpes)	☐ Y	☐ N
HIV(+) or AIDS	☐ Y	☐ N

HAVE YOU EVER

Been hospitalized?	☐ Y	☐ N
Had a surgery?	☐ Y	☐ N
Had an accident?	☐ Y	☐ N

OTHER

Frequent sore throat	☐ Y	☐ N
Lymph node enlargement (gland)	☐ Y	☐ N
Smoking	☐ Y	☐ N
Alcohol	☐ Y	☐ N
Alcohol/drug therapy	☐ Y	☐ N
Tumor diagnosis	☐ Y	☐ N
Radiotherapy	☐ Y	☐ N
Chemotherapy	☐ Y	☐ N
Use of bisphosphanates (fosamax, zometa etc.)	☐ Y	☐ N
[In woman) pregnancy	☐ Y	☐ N

DRUG ALLERGY AND SIDE EFFECTS

Penicillin	☐ Y	☐ N
Local anesthesia	☐ Y	☐ N
Erythromycin	☐ Y	☐ N
Codeine	☐ Y	☐ N
Aspirin	☐ Y	☐ N
General anesthesia	☐ Y	☐ N
Sleeping pills / sedatives	☐ Y	☐ N
Other	☐ Y	☐ N

If yes names of drug(s)

DRUGS THAT YOU USE CONTINUOUSLY / ARE STILL USING

Blood thinners / aspirin	☐ Y	☐ N
Cortisone	☐ Y	☐ N
Sedatives	☐ Y	☐ N
Nitroglycerin	☐ Y	☐ N
Penicillin	☐ Y	☐ N
Pain killers	☐ Y	☐ N
Digital / heart medication	☐ Y	☐ N
Blood pressure medication	☐ Y	☐ N
[In woman) Birth control pills	☐ Y	☐ N
Other	☐ Y	☐ N

If yes names of drug(s)

Have you been to a doctor in the last year?	☐ Y	☐ N
Name of the doctor:		
Have you been to a dentist in the last year?	☐ Y	☐ N
Name of the Dentist:		

OTHER CONDITIONS THAT YOU WANT TO MENTION:

Extra Non-Medical Services

Do you request flight tickets for your travel? ☐ Y ☐ N

Do you request hotel booking? ☐ Y ☐ N

Do you request touristic activities? ☐ Y ☐ N

If yes please select

Complete-day cultural city tour ☐ Half-day city tour ☐

Do you request an interpreter? ☐ Y ☐ N

Please specify your language:……..

Please specify how many people will profit by these services: ……

I declare that above questions were answered by myself and my answers are correct.

Date:..... / ..... / 20.... Patient Surname/Name - signature :