

This form should be filled with complete and accurate information received according to the information gained from the patient, diagnosis of physical examinations, test results and polyclinic records. For non-emergency treatments and surgeries, provisions should be provided 24 hours prior to the treatment/surgery.

Provision/Contact Information

Phone : (216)- 571 5656

Provision Nr :

**This section will be filled out by the Health Institution**

Instution Name	Instution Code	Phone Nr	Fax Nr
Insured's Name - Surname			
Date Of Birth	...../...../.....	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Policy Nr		Card Nr	
Identification Nr.		Contact Phone (Home)	
Identification Card Nr.		Contact Phone (GSM)	
Application Date	...../...../.....		
Address			
Admission / Expiry Date	...../...../.....	...../...../.....	

**This section will be filled out by the physician who completed the examination**

Complaints of the Patient/Story	
Initial Date of the Complaint	...../...../..... (Last Period Date if Pregnant) ...../...../.....
Was there a prior situation caused a physician consult, examination and have you been treated by the same complaint/condition? (Consulted health institution/ name of the physician)	
Patient History / Drugs used	
Diagnosis of Physical Examination	
Examinations / Results	ICD 10
Pre Diagnosis / Diagnosis	<input type="checkbox"/> Out-Patient <input type="checkbox"/> Surgical <input type="checkbox"/> Emergency <input type="checkbox"/> Forensic Case <input type="checkbox"/> Observation <input type="checkbox"/> Pregnancy
Planned Treatment / Process	

Physician's Name/Surname		Operator	
Specialty	<input type="checkbox"/> Contracted <input type="checkbox"/> Non-	Anesthesia	
Contact Phone	<input type="checkbox"/> Contracted	Asisstant	
Signature / Cachet			

**Insured / Policy Holder / Decleration of the Legal Representative**

I declare and accept that the information stated above are exactly correct and accurate, I give full responsibility to the insurance company to gain all information and documents about myself and my family regarding our mentioned/other conditions.

Insured / Policy Holder :

Name/Surname of the Legal Representative :

Signature :

Date:

Date :