**PRIVATE HEALTH INSURANCE**
**PATIENT INQUİRY FORM**

AKSigorta
Bambaşka.

**This form should be filled with complete and accurate information received according to the information gained from the patient, diagnosis of physicial examinations, test results and policlinic 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 | ☐ Male ☐ 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 sittuation 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 | | ☐ Out-Patient ☐ Surgicial<br>☐ Emergancy ☐ Forensic Case<br>☐ Observation ☐ Pregnancy | |
| Planned Treatment / Process | | | |

| | | | |
|---|---|---|---|
| Physician's Name/Surname | | ☐ Contracted<br>☐ Non-Contracted | Operator |
| Specialty | | | Anesthesia |
| Contact Phone | | | Asisstant |
| Signature / Cachet | | | |

**I nsured / 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 :



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