GEBZE TECHNICAL UNIVERSITY HEALTH CULTURE SPORTS DEPARTMENT

DENTISTRY ANAMNESS AND SIGNIFICANT DISTRIBUTION

**The Patient:**

Name :…………………………………………. Surname :…………………………… Tc/Passport Number:………………………………………..

Date of birth : ……………………………..

Telephone number(house): ……………………… Work …………..…..…….. Mobile …………….……………….

**Academic / Administrative Staff:**

Record Number:……………

Worked unit / Department/ Faculty:………………………………….

**Student:**

Student number:…………………………

Faculty and class:………………………….

**Academic / Administrative Staff Nearness:**

Proximity and the name of your staff member:…………………………………..
Registration number of staff working in the institution:…………………………

Unit / department / faculty of personnel working in the institution:…………………………………..

1. Do you have any treatment at the moment? Do you use medication? ……………………………………..

…………………………………………………………………………………………………...……….

2. Do you have any illness or have you passed?

Heart diseases Drug allergy

Diabetes Veneral disease

Tension/blood pressure İcterus

Epilepsy Asthma

Rheumatic fever Kidney, liver disorders

Arthritis Lung diseases

Goiter AIDS

Blood Hepatitis B-C

Other ………………………..

3. Have you had radiation therapy to the head and neck region? ……………………………...………………….

4. Does bleeding take a long time after surgical intervention or injury? ………………………..…………

5. Do you have any medical problems other than these? ……………………………………………….

6. Pregnancy, low, menstruation and menopausal information in women: …………………………………………………………
I approve the accuracy of the information I give about my general health.

Below I was informed about the signature of the patient / patient's vet / patient, the diagnosis of the disease by the dentist, treatment plan and alternative treatments.
I accepted the recommended treatments.
I explained, understood and accepted that the planning of suspicious treatments could change.
All my questions about my treatments or my child ………………………………..'s treatment were answered.
I confirm the accuracy of the information I give.. (Write this sentence in the lower right margin.)

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| SIGNATURE: | DATE: |
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Treatment planning:

 55 54 53 52 51 61 62 63 64 65

18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28

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48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38

 85 84 83 82 81 71 72 73 74 75

date process date process

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I made the appropriate treatment plan according to the information given by the patient.
I gave the necessary information about the patient's disease and treatment, explained the possible risks, and answered the questions.

Name: Signature :