ERCIYES UNIVERSITY
FACULTY OF DENTISTRY
ORAL AND MAXILLOFACIALSURGERY
HOSPITAL

PATIENT ACCEPTANCE FORM

File no:……..

Inspection date:……

Name and surname :…….

Father name :……..

Birth place and date :……..

Social security :…….

referred patient? : ……...

adress and phone number of the patient's relative:…….

Short story:……

…….

physical findings:……..
diagnosis:……..

Precautions to be taken if lying down:……..

Patient Room Number:……

Name and surname of the doctor who hospitalized the patient:……
Signature:……..

Patient Hospitalization
Time:……

Name and Surname of the Clinic Officer:…… signature:…….

This document, which states that I or my patient is in the hospital, knowing the articles in the in-hospital rules, that I have to comply with it, that I accept the necessary medical and surgical treatments, and that I will not act against the hospital rules for any reason, has been signed by me and given to the hospital management.

…/…/…

Patient or Parent
name, surname, signature