Nil Yücel, D.D.S.

450 Sutter Street, Suite 1710
San Francisco, CA 94108

Office (415) 362-3762
Fax (415) 362-3763

PATIENT INFORMATION RECORD

The following confidential information is for our records only.

Title: ☐Mr. ☐Miss. ☐Ms. ☐Mrs. ☐Dr. ☐Other

Name: _____
Last Name First Name Middle Initial

Address: _____
Street Apartment # City Zip Code

What Name Do You Prefer Us to Use? _____ Sex: ☐M ☐F Date of Birth: _____

Status: ☐Single ☐Married ☐Child ☐Other Social Security Number: _____

Driver's License Number: _____ Other ID's: _____

Name of Person Responsible for Account: _____ Relationship: _____

Home Phone: ( ) _____ Work Phone: ( ) _____X____ Fax: ( ) _____

Cell Phone: ( ) _____ Other: _____ E-mail: _____

Employer Name & Address: _____

Occupation: _____ Whom May We Thank For Referring You? _____

Physician's Name: _____ Phone No: _____

Name of Contact Person In Case Of Emergency: _____ Phone #: _____

INSURANCE INFORMATION

Insured's Name: _____ SS#: _____ Birthdate: _____

Name of Insurance Company: _____ Phone #: ( ) _____

Address: _____ Group #: _____
Street City Zip Code

Do You Have A Secondary Insurance Company? _____

ALL PATIENTS ARE RESPONSIBLE FOR PAYMENT OF FEES. If you have insurance, we will gladly process your forms, but a payment is expected on the day of service. If you can not keep an appointment, please give us 48 hours notice so that the time may be given to another patient. We understand that emergencies do arise; however **cancellations without 48 hour notice may result in a cancellation charge of $100.00 per hour.**

I understand that any procedure carries some risk. I will give my consent only when risks, benefits and alternatives are discussed.
I understand and agree to the insurance/financial and cancellation policy. In addition, I hereby authorize Nil Yücel D.D.S. to sign and submit insurance claims on my behalf. I understand that this authorization will assign all insurance benefits directly to Dr. Yücel.

_____
Signed (Patient or Legal Guardian) Date