Linda D. Dahl, M.D.
Diplomate American Board of Otolaryngology

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Patient Information

Name:_____ Gender: M F Date of Birth:_____

Address:_____

City/State/Zip:_____

Home Phone:_____ Mobile:_____ Email:_____

SS#:_____ Ethnicity:_____ Marital status:_____

Employed by: _____ Occupation:_____

Address:_____ Phone:_____

Emergency Contact:_____ Mobile:_____

Pharmacy name/address:_____ Pharmacy Phone:_____

Reason for today's visit? _____Who referred you? _____

Primary care doctor:_____ Phone:_____

(for singers) Voice teacher:_____ Phone:_____

Insurance Information

Primary Insurance: _____ ID#:_____

Secondary Insurance:_____ ID#:_____

Guarantor Information

Person responsible for account: _____ Date of birth:_____

Relationship to patient:_____ SS#_____

Address (if different from patient)_____

City/State/Zip_____Phone:_____

Assignment & Release

I, the undersigned, hereby certify that I (or my dependent) has insurance coverage with the above noted insurance company and assign directly to Linda Dahl MD, all insurance benefits. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Signature:_____ Date:_____

Cancellation Policy

If you do not show up for an appointment or cancel with less than 24 hours notice, you will be billed a flat fee of $150. Weekends and holidays are not considered in those 24 hours. If you are canceling a Monday morning appointment, you must do so by the previous Friday morning. I hereby understand the cancellation policy.

Signature:_____ Date:_____