Breastfeeding the way it was meant to be

120 East 56th Street Suite 300
New York, NY 10022
212-920-3047
www.dahlfull.com

Patient Information

Baby's name:____ Gender: M F Date of Birth:________________________

SS#:____
Ethnicity:____

Reason for today's visit?____

Who referred you? ____

Pediatrician:____ Phone:_____________________________________

Parent information

Mother____ Date of Birth:_____________________________

Father____ Date of Birth:_____________________________

Address:____

City/State/Zip:____

Phone:____________________________________ Email:____

Insurance Information

Primary Insurance: ____ ID ____

Guarantor Information

Person responsible for account: ____

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

Please arrive 15 minutes before your scheduled appointment to ensure time for insurance eligibility. 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. I hereby understand the cancellation policy.

Signature:____

Date:____________________________________