

# CONFIDENTIAL INFORMATION QUESTIONNAIRE

*Please Print*

PATIENT'S NAME		LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #
PATIENT'S ADDRESS		STREET	APT#	CITY	STATE	ZIP	HOME PHONE
MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> UNDER AGE 18		PATIENT'S/GUARDIAN'S EMPLOYER			OCCUPATION		
WORK ADDRESS		STREET	CITY	STATE	ZIP	WORK PHONE	OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO
SPOUSE'S NAME		LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER		OCCUPATION
WORK ADDRESS		STREET	CITY	STATE	ZIP	WORK PHONE	OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)							
NAME		RELATIONSHIP		WORK #		HOME#	
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE				WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE			
<b>INSURANCE AND FINANCIAL INFORMATION</b>							
INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME			INSURANCE ADDRESS		
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBER'S SSN	
GROUP/PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS		
SECONDARY COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME			INSURANCE ADDRESS		
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBER'S SSN	
GROUP/PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS		

**WILLIAM T. LINK, DDS, PA**

**PATIENT CONSENT/ACKNOWLEDGMENT FORM**

By signing below, you consent to the use and disclosure of your protected health information by William T. Link, DDS, PA, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices (“Notice”). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at (828) 437-7300 and requesting a revised Notice.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, You may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

Name \_\_\_\_\_ Date \_\_\_\_\_

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN  
THE CONSENT/ ACKNOWLEDGEMENT OF NOTICE OF PRIVACY.

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