MERCE Family Healthcare

Medical Center: 1831 North Fayetteville Street • Asheboro, NC 27203
Phone: 336-672-1300 / Fax: 336-672-3044

Dental Center: 308 Brewer Street • Asheboro, NC 27203
Phone: 336-610-7000 / Fax: 336-610-7003

Patient Information: Please fill out this form completely.

Name: _____ Date: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (County) (Zip Code)

Date of Birth: _____ Phone: Home: _____ Alternate: _____ Sex: [ ] Male [ ] Female

Social Security #: _____ Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Minor

Employer: _____
(Company Name) (Address) (City, State & Zip) (Phone)

Emergency Contact: _____ Phone: _____ Relationship: _____

Email: _____ How did you learn about us: _____

Method of Payment: Full payment for dental services provided, must be paid at the time of service. For your convenience, we accept cash, checks, Visa, MasterCard & Discover. For our patients who need extended dental care, we offer payment plans. Payment plans MUST be discussed with and written by the dental practice manager.

Insurance Information: Please check the appropriate box that applies to patient:

[ ] STAR Card (Sliding Fee Assistance Program) [ ] No Coverage [ ] Medicaid ID #: _____

[ ] Health Choice ID #: _____ [ ] Private Insurance ID #: _____ Group #: _____

Please provide a copy of any insurance cards to the front desk so that the proper information can be filed at your convenience. If cards are not available, we will not be able to process any claims, therefore you will be responsible for all expenses incurred.

Guarantor/Responsible Party: Only complete if responsible party is NOT the patient:

Name: _____ Date of Birth: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____ Relationship: _____ Social Security #: _____

Employer: _____
(Company Name) (Address) (City, State & Zip) (Phone)

Assignment of Benefits, Release of Information, Payment Agreement:

I understand that payment is due at the time of service unless other arrangements have been made. I agree that I am responsible for full payment of this account and any court costs/attorney fees associated with the collection of this account. I permit MERCE Family Healthcare to release any information deemed necessary to any insurance or third party within the guidelines of HIPPA.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____

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