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 REGISTRATION – NEW AND UPDATE - Please Print TODAY'S DATE______________

Patient Information: **Are you *also* a patient at DENTAL? ______ If yes, have you been seen at Dental since 1/1/2021? ______**

Name: Last: _______________ First: ___________MI: ____ Date of Birth: ________________ Social Security #: _______________
Sex: M F Marital Status: ____ Single ____ Married ____Divorced ____ Widowed ____ Minor
Address: ____ City: _________________________ State: ___________ Zip: __________
Phone: Home: ________________________ Work: _____________________ Cell: ______________________
Student Status: _____ Full time _____ Part time
Employment Status: _____ Full time _____ Part time _____ Retired ____ Unemployed
Employer: ____ Employer Phone: ______________________
Employer Address: _______________________________ City: _________________________ State: ___________ Zip: ___________

Emergency Contact: Name: ____ Relationship: ________________________

Phone Number: ___________________________________

Guarantor/Guardian/Responsible Party Information:
Name: Last: _______________ First: ___________MI: ____ Date of Birth: ________________ Social Security #: _______________
Address: ____ City: _________________________ State: ___________ Zip: __________
Phone: Home: ________________________ Work: _____________________ Cell: ______________________
Employer (Company Name): ____ Phone: ____________________
Employer Address: _______________________________ City: ______________________ State: _____________ Zip: ___________

Demographics: Because we are a Federally Qualified Health Center (FQHC), we are required to collect specific information to help better serve our community. Please answer the following questions completely.
Are you homeless? ____ Y ____ N Does someone else provide you with shelter? ___ Y ___ N

Do you live in public housing? ____Y ____N

Ethnicity (check if applicable) ____ Latino ____ Hispanic ____Not Hispanic or Latino ____ Refuse to answer

Race (check all that apply): ____White/Caucasian ____ Asian ____ More than one race ____ Veteran
____ Black/African American ____ Native Hawaiian ____ Refuse to answer ____ Migrant Farm Worker
____ Native American/Alaskan ____ Other Pacific Islander ____ Seasonal Farm Worker

Patient Email Address: ____

Have you been seen since 1/1/2021? ____ Y ____ N

PRIMARY Insurance Information:
Insurance: _____ Yes _____ No
Primary Insurance Company Name: ____
Insurance Company Address: ____
Policy #: _________________________________ Policy Holder: ______________________________
Relationship to you: ________________________ Group #: ___________________________________

Medicaid: _____ Yes _____ No ID#: ____________________
(Medicaid Only) Is MERCE Family Healthcare your Primary Care Provider _____ Yes _____ No
Medicare: _____ Yes _____ No ID#: ____________________
Star SFS: _____ Yes _____ No Level: ___________________
Preferred Pharmacy: _______________________

SECONDARY Insurance Information:

Insurance: _____ Yes _____ No
Secondary Insurance Company Name: ______________________________
Insurance Company Address: ______________________________
Policy #: ____________________ Policy Holder: ____________________
Relationship to you: ____________________ Group #: ____________________

Medicaid: _____ Yes _____ No ID#: ____________________
Medicare: _____ Yes _____ No ID#: ____________________
Star SFS: _____ Yes _____ No Level: ____________________
Preferred Pharmacy: ____________________

Referral: How did you learn about MERCE Family Healthcare? Please check all that apply:

_____Physician/Dentist
_____Phone book
_____MERCE Medical
_____MERCE Urgent Care
_____Social Services
_____Internet/Website
_____MERCE Dental
_____MERCE Behavioral Health
_____Health Department
_____Friend/Family
_____Other health fair/event
_____Other: _______________
_____Newspaper
_____Current Patient
_____ Other provider

Assignment of Benefits, Release of Information, Payment Agreement, HIPAA Guidelines

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 and attorney fees associated with the collection of this account.

I understand that MERCE Family Healthcare will be filing my insurance on my behalf. I agree to have the benefits from my insurance assigned to MERCE Family Healthcare. I permit MERCE Family Healthcare to release any information deemed necessary to any insurance or third party, within the guidelines of HIPAA (Health Insurance Portability & Accountability Act of 1996).

A copy of this document is valid as original.

Patient Signature: ______________________________ Date: ____________________

Responsible Party Signature: ______________________________ Date: ____________________