



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 1/1/2017? _____

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 1/1/2017? _____ 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 ____ Social Services ____ Health Department ____ Newspaper
____ Phone book ____ Internet ____ Friend/Family ____ Current Patient
____ MERCE Medical ____ MERCE Dental ____ Other health fair/event ____ Other _____

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: _____

