Maple Street Clinic Patient Registration

109 E. Maple Street
Gillespie, IL 62033
217-839-1526 - Medical
217-839-4110 - Dental

Patient Information:

First Name: _____ MI: _____ Last Name: _____ Suffix: _____

Social Security Number: ___-___-___ Date of Birth: ___/___/

Sex: □ Male □ Female □ Other □ Female to Male □ Male to Female □ Declined to Specify

Sexual Orientation: □ Straight □ Lesbian/Gay □ Bisexual □ Something Else □ Don't Know □ Declined to Specify

Address: _____
(Street Address) (City) (State) (Zip)
Mailing Address (if different): _____
(Mailing Address) (City) (State) (Zip)
Home Number: _____ Cell Number: _____

Email address: _____ Birth Mother's Maiden Name:_____

How do you prefer to be contacted? □ Home Phone □ Cell Phone □ Email □ Mailing address

Race (mark ALL that apply)
□ American Indian/Alaskan Native □ Asian □ Black/African American □ Declined To Specify
□ More Than One Race □ Native Hawaiian □ Other Pacific Islander □ White

Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Latino □Unknown

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Are you a student? □ YES □ NO Are you a Veteran? □ YES □ NO

Are you a Smoker? □ YES □NO Are you a Migrant Worker? □ YES □ NO

Housing: □ Own □ Rent □ Income-Based/Public Housing
□ Homeless □Living with Friends/Family

Place of Employment: _____ Work Telephone Number: _____
What is the approximate annual household income? _____ Family Size_____

PARENT'S INFORMATION (if patient is a child)

First Name: _____ MI: _____ Last Name: _____ Suffix: _____

Social Security Number: ___-___-___ Date of Birth: ___/___/___ Sex: □ Male □ Female

Address: _____
(Mailing Address) (City) (State) (Zip)

INSURANCE INFORMATION: Check all that apply

□ MEDICAID □ ALLKIDS □ MEDICARE □ PRIVATE INSURANCE

□SELFPAY □ SLIDING FEE

Insurance Policy Information:

Name of Policy Holder: _____

Social Security Number of Policy Holder: _____ Date of Birth: _____

Name of Medical Insurance: _____

Policy Number: _____ Member number: _____ Effective date: _____

Name of Dental Insurance: _____

Policy Number: _____ Member number: _____ Effective date: _____

EMERGENCY CONTACT INFORMATION:

Name: _____

Relationship: _____ Phone Number: _____

HOW DID YOU HEAR ABOUT US?

_____

All clients have the right to treatment by Macoupin County Public Health Department Maple Street Clinic without discrimination to age, race, color, religion, sex, sexual orientation or national origin.

The above information is true and correct to the best of my knowledge.

I accept full responsibility for my/my child's care and treatment and release The Maple Street Clinic and staff of any and all liability for any adverse results that may occur due to my refusal to follow the recommended plan of treatment.

I authorize Macoupin County Public Health Maple Street Clinic to provide service to me and to release necessary information to bill, process, and receive payment of Medical/Dental Benefits (private insurance, Medicare, or Medicaid, etc.), for Medical and Professional Services Rendered.

I understand that new registration documents are required a minimum of once per year.

Client (or Parent) Signature: _____ Date: _____