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

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

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

Home Number: _____ Cell Number: _____

Email address: _____

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

Birth Mother's Maiden Name: _____

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: _____

Update One Year Later Signature:_____Date:_____

Macoupin County Public Health Department

Acknowledgment of Notice of Privacy Practices

My signature below indicates that I have been given an opportunity to read the Notice Of Privacy Practices for the **Macoupin County Public Health Department**, and to have any questions answered before signing.

**Signed: _____ Date: _____

Printed Name: _____

If signed by someone other than the patient, please indicate relationship to patient:

( ) Parent or guardian of minor patient ( ) Guardian or conservator of an incompetent patient

( ) Beneficiary or personal representative of deceased patient

FOR OFFICE USE ONLY:

Employee Signature: _____ Date: _____

If patient or patient's representative refuses to sign this Acknowledgment:

( ) Efforts to Obtain: _____( ) Reason patient refused to sign:_____

Consent to Release Information to Designated Family Member or Caregiver

The names listed below are allowed to have information released to them from Macoupin County Public Health Department with the undersigned consent.

_____	_____
Name to receive information and relationship	Type of information **not** to release
_____	_____
Name to receive information and relationship	Type of information **not** to release
_____	_____
Name to receive information and relationship	Type of information **not** to release
_____	_____
Name to receive information and relationship	Type of information **not** to release

This consent remains in effect for one (1) year period and will be updated and signed on a yearly basis or as needed per patient request. This consent may be revoked at any time upon written request.

**Signature:_____ Date_____

*Update One Year Later Signature:*_____ *Date:*_____

Macoupin County Maple Street Dental Clinic

109 E. Maple Street
Gillespie, IL 62033

CONSENT TO TREATMENT FOR A CHILD

Maple Street Dental Clinic requires that all parent/legal guardians bring their child to their first appointment. This is necessary to complete all forms and to sign consent for treatment. Consent to treatment allows those names listed to bring the child to our facility for treatment. However, a parent/legal guardian must bring the child to any appointment requiring an extraction.

This consent is effective for one year. After one year consent must be renewed.

Please sign the following consent if your child may be brought to his/her appointment by another adult (over 18 years of age).

I,_____, hereby give my consent for dental treatment of
(Parent/Legal Guardian)

_____DOB_____ by the staff of Maple Street Dental Clinic.
(Child's name) (Child's birthdate)

I give the consent for the following adults to bring my child to his/her dental appointments:

1. _____
(Name and Relationship to Child)

2. _____
(Name and Relationship to Child)

3. _____
(Name and Relationship to Child)

4. _____
(Name and Relationship to Child)

Printed name of Parent/Legal Guardian_____

Signature of Parent/Legal Guardian_____

Today's Date_____ This consent will expire in one year from today's date.

Parent/legal guardians have the right to add or change the names listed at any time.

*Update One Year Later Signature:*_____ *Date:*_____