MAPLE STREET CLINIC PATIENT REGISTRATION

DATE_____

PLEASE PRINT: PATIENT PRIMARY MEDICAL INS_____

PATIENT NAME: _____MI_____LAST_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOUSING: OWN HOME_____RENT_____PUBLIC HOUSING_____HOMELESS_____

HOME PHONE#_____-_____-_____CELL PHONE#_____-_____-_____

PATIENT PLACE OF EMPLOYMENT_____WORK#____-_____-_____

PATIENT DATE OF BIRTH____-_____-____AGE____SEX: M OR F PT. SS#_____-____-___

MARTIAL STATUS: MARRIED____SINGLE_____DIVORCED_____WIDOWED_____

IF THE PATIENT IS A CHILD, WHO IS THE RESPONSIBLE PARTY?

NAME: _____ DATE OF BIRTH_____-_____-_____

ADDRESS_____CITY_____STATE_____ZIP_____

SS#_____-_____-_____

INSURANCE INFORMATION: PLEASE CIRCLE ALL THAT APPLY

MEDICAID KIDCARE MEDICARE DENTAL INS SELF PAY

IF YOU HAVE DENTAL INSURACE, WHAT IS THE PLAN NAME_____

GROUP #_____ NAME OF POLICYHOLDER_____SS#____-____-____

PATIENT MEDICARE/MEDICAID#_____

PATIENT ETHNICITY: HISPANIC/LATINO NON HISPANIC/LATINO

PATIENT RACE: WHITE____ BLACK/AFRICAN AMERICAN____ AMERICAN INDIAN____ASIAN___

EMERGENCY CONTACT:

NAME_____RELATIONSHIP_____

PHONE#_____-_____-_____

ALL CLIENTS HAVE THE RIGHT TO TREATMENT BY MACOUPIN COUNTY PUBLIC HEALTH DEPARTMENT CLINICS WITHOUT DISCRIMINATION TO AGE, RACE, COLOR, RELIGION, SEX, SEXUAL ORIENTATION OR NATIONAL ORIGIN.

I ACCEPT FULL RESPONSIBITY FOR MY/MY CHILD'S CARE AND TREATMENT AND RELEASE MACOUPIN HEALTH CLINCS 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 MACOPUIN COUNTY HEALTH 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.

CLIENT (OR PARENT) SIGNATURE_____

DATE_____