

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



Morgan Street Clinic  
 1115 Morgan Street  
 Carlinville, IL 62626  
 217-854-3692 – Medical/Behavioral  
 217-854-6823 – 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

Address: \_\_\_\_\_  
 (Street Address) (City) (State) (Zip)

Mailing Address (if different): \_\_\_\_\_  
 (Street Address) (City) (State) (Zip)

Primary Phone Number: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_ Mother's Maiden Name: \_\_\_\_\_

How do you prefer to be contacted?  Primary Phone  Alternate 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

**How many people live in your home?** \_\_\_\_\_ **What is your household annual income?** (check one below)

\$0-\$10,000  \$10,001-\$20,000  \$20,001-\$30,000  \$30,001-\$40,000  \$40,001-\$50,000  \$50,001+

**PARENT'S INFORMATION (if patient is a child)**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_  
 (Street Address) (City) (State) (Zip)

**Turn page over →**

**INSURANCE INFORMATION: Check all that apply**

- MEDICAID       ALL KIDS       MEDICARE       PRIVATE INSURANCE
- SELF PAY       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?**

- FAMILY MEMBER/FRIEND       SOCIAL MEDIA       DOCTOR       VA       SCHOOL
- I AM A CURRENT PATIENT       BROCHURE       OTHER (please specify)\_\_\_\_\_

**All clients have the right to treatment by Macoupin County Public Health Department at Maple Street and Morgan Street Clinics 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 and Morgan Street Clinics 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 Department, Maple Street Clinic, and Morgan Street Clinic, to provide services 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:** \_\_\_\_\_

**Relationship to Patient if a minor:** \_\_\_\_\_