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

Macoupin County
Public Health Department

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: _____