

MATHERS CLINIC, LLC
NEW PATIENT REGISTRATION FORM
 (Please print)

Last Name: _____ First: _____ M: _____
 Age: _____ Date of Birth: _____ Email: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Social Security: _____ Home Phone: _____
 Mobile: _____ Work: _____ Marital Status: _____
 Employer: _____
 Person to Notify in Emergency: _____ Phone: _____
 Referred By: _____

FINANCIAL RESPONSIBILITY:

The person signing this form is the responsible financial party, unless another party has completed a separate financial responsibility form

Last Name: _____ First: _____ M: _____
 Date of Birth: _____ Social Security: _____
 Relationship to Patient: _____ Email: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____

PRIMARY INSURANCE INFORMATION:

Name of Insurance Company: _____ Address: _____
 Phone Number: _____ ID#: _____ Group#: _____
 Policy Holder's Name: _____ Policy Holder's DOB: _____
 Patient's Relationship to Policy Holder: **Child | Spouse | Other** Policy Holder's SSN#: _____
 (Please circle one)

SECONDARY INSURANCE INFORMATION:

Name of Insurance Company: _____ Address: _____
 Phone Number: _____ ID#: _____ Group#: _____
 Policy Holder's Name: _____ Policy Holder's DOB: _____
 Patient's Relationship to Policy Holder: **Child | Spouse | Other** Policy Holder's SSN#: _____
 (Please circle one)



CRYSTAL LAKE: 145 S Virginia St, Crystal Lake, IL 60014
 ROCKFORD: 6090 Strathmoor Dr, Ste 1, Rockford, IL 61107
 WOODSTOCK: 715 W Judd St, Woodstock, IL 60098

PHONE: 815.444.9999
 FAX: 815.986.1363
 www.themathersclinic.com