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)

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