New Patient Registration Form *(Please print)*

Last Name: _____ First: _____ M:____

Age: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Social Security: _____ Home Phone: _____

Mobile: _____ Work: _____ Marital Status: _____

Employer: _____ Spouse Name: _____

Spouse Social Security Number: _____

Spouse Employer: _____

Person to Notify in Emergency: _____ Phone: _____

Referred By: _____

Financial Responsibility:

Last Name: _____ First: _____ M: ____

Date of Birth: _____ Social Security: _____

Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Insurance Information:

Name of Insurance Company _____ Address: _____

Phone Number: _____ ID#: _____

Policyholder's Name: _____ Policy Holder's DOB: _____

Group Number: _____

Secondary Insurance Information:

Name of Insurance Company _____ Address: _____

Phone Number: _____ ID#: _____

Policyholder's Name: _____ Policy Holder's DOB: _____

Group Number: _____

MATHERS CLINIC

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81 E Grand Ave, Fox Lake, IL 60020	phone: 224.908.3005	fax: 847.531.1296	themathersrecovery.com	
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