

## McLaren Print System Order

Order No: 63113 Reprint Previous Order No: 5523  
 Order Date: 2021-06-21  
 User: Tammy Sagamang  
 Phone: 810-342-5820

Ship Location: McLaren Int. Med. Res. Group Practice-Attn: Tammy  
 3230 Beecher Road Ste 2-Med Ed Bldg  
 Flint , MI 48532

### Forms

Quantity: 1000  
 Paragon Dept No: 60030  
 Dept Name: McLaren Int. Med. Res. Group Practice  
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-17305A  
 Item Description: Adult Registration  
 Revision Date: 5/2017  
 Print: 1 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: None  
 Misc Info:

MCLAREN MEDICAL GROUP ADULT REGISTRATION		Language Preference: English Other specify:		
PATIENT INFORMATION	PREFIX NAME: _____ LAST: _____ FIRST: _____ MIDDLE: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ TELEPHONE: _____ HOME: _____ WORK: _____ CELL PHONE: _____ E-MAIL ADDRESS: _____ EMPLOYER: _____ OCCUPATION: _____ HOW LONG EMPLOYED: _____ EMPLOYER TELEPHONE: _____ EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ PRESENT CARE PROVIDER: _____ REFERRED OR RECOMMENDED BY: _____	SPECIALTY: _____ A. Family    B. Internal    C. General    D. Pediatrics E. Geriatrics    F. Gynecology    G. Obstetrics    H. Pediatrics I. Cardiology    J. Endocrinology    K. Gastroenterology    L. Hematology M. Infectious Disease    N. Neurology    O. Oncology    P. Orthopedics Q. Otolaryngology    R. Radiology    S. Urology    T. Dermatology U. Ophthalmology    V. Plastic Surgery    W. Pulmonary    X. Rheumatology Y. Other _____		
	For appointment reminders only, use phone number _____ and E-mail _____ For texting & message, use phone number _____			
	SPOUSE / LEGAL GUARDIAN INFORMATION	NAME: _____ LAST: _____ FIRST: _____ MIDDLE: _____ RELATIONSHIP: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ EMPLOYER: _____ OCCUPATION: _____ HOW LONG EMPLOYED: _____ EMPLOYER TELEPHONE: _____ EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____		
		PRESENT INSURANCE: _____ SUBSCRIBER: _____ BIRTH DATE: _____ POLICY # _____ GROUP # _____ EMPLOYEE CATEGORIES: _____ GROUP NAME: _____ SECONDARY INSURANCE: _____ SUBSCRIBER: _____ BIRTH DATE: _____ POLICY # _____ GROUP # _____ EMPLOYEE CATEGORIES: _____ GROUP NAME: _____		
OTHER INFORMATION	NEAREST RELATIVE NOT RESIDING AT SAME ADDRESS NAME: _____ RELATIONSHIP: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ HOME TELEPHONE: _____ HOME TELEPHONE: _____ EMERGENCY CONTACT: _____ RELATIONSHIP: _____ TELEPHONE: _____			
	REFERENCE SIGNATURE: _____ DATE: _____ SIGNATURE: _____ DATE: _____ SIGNATURE: _____ DATE: _____			