

McLaren Print System Order

Order No: 47809 Reprint Previous Order No: 5607  
Order Date: 2019-08-19  
User: nicole jones  
Phone: 8106644531

Ship Location: Lapeer CMC  
1254 North Main Street  
Lapeer, mi 48446

Forms

Quantity: 500  
Paragon Dept No: 50504  
Dept Name: Lapeer CMC  
Company Number: 810

Order Total Price: 0.00

Item Number: MM-17305B  
Item Description: Child / Adolescent Registration  
Revision Date: 7/2016  
Print: 1 sided black and white  
Paper: 20# White Text  
Size: 8.5 x 11  
Fold:  
Finish:  
Drill: None  
Misc Info:

**McLAREN MEDICAL GROUP** Language Preference: English  
**CHILD/ADOLESCENT REGISTRATION** Other specify

**PARENT INFORMATION**

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	SEX	RELATIONSHIP	LANGUAGE	ETHNICITY	RACE
ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE	WORKING	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Cantonese <input type="checkbox"/> Tagalog <input type="checkbox"/> Hindi <input type="checkbox"/> Urdu <input type="checkbox"/> Arabic <input type="checkbox"/> Chinese <input type="checkbox"/> Other	<input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other	
PARENT/GUARDIAN		RELATIONSHIP		PARENT/GUARDIAN		RELATIONSHIP		

For appointment reminders only, use phone number \_\_\_\_\_ and E-mail \_\_\_\_\_  
For leaving a message, use phone number \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH		
ADDRESS		ADDRESS			
CITY	STATE	ZIP	CITY	STATE	ZIP
TELEPHONE	WORKING	TELEPHONE	WORKING		
SEX	RELATIONSHIP	SEX	RELATIONSHIP		
EMPLOYER ADDRESS		EMPLOYER ADDRESS			
EMPLOYER TELEPHONE	HOW LONG EMPLOYED	EMPLOYER TELEPHONE	HOW LONG EMPLOYED		

**INSURANCE INFORMATION**

PRIMARY INSURANCE	INSURANCE	DATE OF BIRTH	
POLICY #	GROUP #	EMPLOYER EMPANSEID	GROUP NAME
SECONDARY INSURANCE	INSURANCE	DATE OF BIRTH	
POLICY #	GROUP #	EMPLOYER EMPANSEID	GROUP NAME

**NEAREST RELATIVE NOT RESIDING AT SAME ADDRESS**

NAME	RELATIONSHIP		
ADDRESS	CITY	STATE	ZIP CODE
HOME TELEPHONE	HOME TELEPHONE		
EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE	

**UPDATES**

PHYSICIAN SIGNATURE	DATE		
DATE	SIGNATURE	DATE	SIGNATURE

MC 17305B-16 CHILD REGISTRATION