McLaren FLINT

PATIENT ACCESS (810) 342-2936

PATIENT INFORMATION (Please Print) Date:

PATIENT NAME FIRST MIDDLE LAST	SEX ☐ M ☐ F	MARITAL STATUS S M W D	RACE	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.

STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO. ( )

IF PATIENT IS A MINOR (MOTHER'S NAME/FATHER'S NAME) INCLUDE SOC. SEC. # AND DOB	EMAIL: MyMclaren chart	CELL PHONE NO. ( )

PATIENT'S EMPLOYER (NAME & ADDRESS)	FULL TIME:__ PART TIME:___ NOT EMPLOYED:____ SELF EMPLOYED:____

DESCRIBE YOUR JOB DUTIES (BE SPECIFIC)	ACTIVE RETIRED DISABLED DATE

PERSON TO CONTACT (OTHER THAN YOUR HOME PHONE NO.)	RELATIONSHIP	CONTACT PHONE NUMBER: ( )

FAMILY DOCTOR (NAME AND PHONE NUMBER)

ADVANCE DIRECTIVE/DPOA:

Do you have an Advance Directive for Healthcare? Y or N Copy provided? Y or N

INJURY INFORMATION

WAS THIS AN INJURY?	INJURY DATE	FOR ACCIDENT CLAIMS ☐ AUTOMOBILE ACCIDENT ☐ WORKER'S COMP ☐ OTHER _____

EXPLAIN HOW AND WHERE THE INJURY OCCURRED

NAME OF WORKMENS COMP OR AUTO INSURANCE CARRIER:

POLICY HOLDER NAME	CLAIM NO.	NAME OF CLAIM REPRESENTATIVE/ATTORNEY	PHONE# ( )

INSURANCE INFORMATION

PRIMARY

INSURANCE COMPANY/CARRIER YES NO PART ☐ ☐ PART A B	POLICY HOLDER'S SOCIAL SECURITY NUMBER
POLICY HOLDER'S NAME	POLICY HOLDER'S BIRTHDATE
CONTRACT / ID NUMBER ON YOUR INSURANCE CARD:	GROUP ON YOUR INSURANCE CARD:
POLICY HOLDER'S RELATIONSHIP TO PATIENT	POLICY HOLDER'S BIRTHDATE

SECONDARY

INSURANCE COMPANY/CARRIER YES NO PART ☐ ☐ PART A B	POLICY HOLDER'S SOCIAL SECURITY NUMBER
POLICY HOLDER'S NAME	POLICY HOLDER'S BIRTHDATE
CONTRACT / ID NUMBER	GROUP
POLICY HOLDER'S RELATIONSHIP TO PATIENT	POLICY HOLDER'S BIRTHDATE