McLAREN MEDICAL GROUP
ADULT REGISTRATION

Language Preference: ☐ English
☐ Other specify: _____

PATIENT INFORMATION

PATIENT NAME (Last) (First) (Middle)	❑ Male ❑ Female	STATUS: ❑ Single ❑ Married ❑ Divorced ❑Widowed
ADDRESS CITY STATE ZIP CODE		LANGUAGE: ❑ English ❑ Spanish ❑ Arabic ❑ German ❑ Polish ❑ French ❑ Italian ❑ Chinese ❑ Declined ETHNICITY: ❑ Hispanic/ Latino ❑ Non-Hispanic/ Latino ❑ Decline to Answer ❑ Unknown RACE: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ White Caucasian ❑ Native Hawaiian or Pacific Islander ❑ Unknown or Decline to Answer
TELEPHONE ( )	SS# ___-___-____	BIRTH DATE __-__-____
CELL PHONE ( )	E-MAIL ADDRESS	
EMPLOYER	OCCUPATION	HOW LONG EMPLOYED / EMPLOYER TELEPHONE ( )
EMPLOYER ADDRESS CITY STATE ZIP CODE		
PRIMARY CARE PHYSICIAN	REFERRED OR RECOMMENDED BY	

For appointment reminders only, use phone number _____ and E-mail _____

For leaving a message, use phone number _____

SPOUSE /LEGAL GUARDIAN INFORMATION

NAME (Last) (First) (Middle)	RELATIONSHIP
TELEPHONE ( ) / SS# ___-___-____	BIRTH DATE __-__-____
ADDRESS CITY STATE ZIP CODE	
EMPLOYER / OCCUPATION / HOW LONG EMPLOYED / EMPLOYER TELEPHONE ( )	
EMPLOYER ADDRESS CITY STATE ZIP CODE	

INSURANCE INFORMATION

PRIMARY INSURANCE	SUBSCRIBER	BIRTH DATE
POLICY # / GROUP #	EMPLOYEE ID#/SS#/MISC / GROUP NAME	

SECONDARY INSURANCE	SUBSCRIBER	BIRTH DATE
POLICY # / GROUP #	EMPLOYEE ID#/SS#/MISC / GROUP NAME	

OTHER INFORMATION

NEAREST RELATIVE NOT RESIDING AT SAME ADDRESS

NAME	RELATIONSHIP
ADDRESS CITY STATE ZIP CODE	
WORK TELEPHONE ( ) / HOME TELEPHONE ( )	
EMERGENCY CONTACT / RELATIONSHIP / TELEPHONE ( )	

UPDATES

PATIENT/LEGAL GUARDIAN SIGNATURE	**DATE**

DATE SIGNATURE	DATE SIGNATURE