MCLAREN HEALTH CARE

REGISTRATION DOWNTIME FORM FIN #: _____

ARRIVAL TIME: _____ MODE OF ARRIVAL: _____

DEMOGRAPHIC INFORMATION

LAST NAME	**FIRST NAME**	**MIDDLE NAME**	**SUFFIX**	**DOB**
SSN#	**GENDER**	**MOTHERS MAIDEN NAME**		**AGE**
STREET ADDRESS	ZIP CODE	CITY	STATE	COUNTY
MAILING ADDRESS	ZIP CODE	CITY	STATE	COUNTY
PHONE	ALTERNATE PHONE	**ETHNICITY**	**RACE**	**LANGUAGE**
ALTERNATE ADDRESS	ZIP CODE	CITY	STATE	COUNTY
PHONE	ALTERNATE PHONE	**STATE BORN**	**RELIGION**	**SB REL**

EMPLOYMENT

EMPLOYMENT STATUS	PLACE OF EMPLOYMENT	EMPLOYMENT ADDRESS	CITY/STATE	ZIP CODE

ENCOUNTER INFORMATION

PATIENT TYPE	REASON FOR VISIT			
REG DATE	**REG TIME**	POINT OF ORIGIN	MEDICAL SERVICE	ADMIT CATEGORY
ACCIDENT RELATED?	ACCIDENT ONSET	ACCIDENT DATE & TIME	ACCIDENT STATE	
ADMIT DATE/TIME	NURSE UNIT/LOCATION	ROOM/BED	ACCOMODATION	
ATTENDING PHYSICIAN	ADMITTING PHYSICIAN	**PRIMARY CARE PHYS**	REFERRING PHYSICIAN	

GUARANTOR INFORMATION

PATIENT'S REL TO GUAR	LAST NAME	FIRST NAME	MIDDLE NAME	DOB
MAILING ADDRESS	ZIP CODE	CITY	STATE	COUNTY
HOME PHONE				

INSURANCE INFORMATION

PRIMARY INSURANCE	SUBSCRIBER	PTS REL TO SUB	SUB DOB	SUB PHONE
SUB MAILING ADDRESS	SUB ZIPCODE	SUB CITY	SUB STATE	SUB COUNTY
CONTRACT NUMBER	GROUP NUMBER			
SECONDARY INSURANCE	SUBSCRIBER	PTS REL TO SUB	SUB DOB	SUB PHONE
SUB MAILING ADDRESS	SUB ZIPCODE	SUB CITY	SUB STATE	SUB COUNTY
CONTRACT NUMBER	GROUP NUMBER			
TERTIARY	SUBSCRIBER	PTS REL TO SUB	SUB DOB	SUB PHONE
SUB MAILING ADDRESS	SUB ZIPCODE	SUB CITY	SUB STATE	SUB COUNTY
CONTRACT NUMBER	GROUP NUMBER			

EMERGENCY CONTACTS

LAST NAME	**FIRST NAME**	**PATIENTS REL TO EC**	ZIP CODE	CITY
COUNTY	COUNTRY	HOME PHONE	ALTERNATE PHONE	
LAST NAME	**FIRST NAME**	**PATIENTS REL TO EC**	ZIP CODE	CITY
COUNTY	COUNTRY	HOME PHONE	ALTERNATE PHONE	