

**McLaren Print System Order**

Order No: 70971 Reprint Previous Order No: 5523  
 Order Date: 2022-07-05  
 User: Kerry Zaske  
 Phone: 989-846-2600

Ship Location: McLaren Standish Family Medicine/ Attn. Kerry Zaske  
 4489 M-61  
 Standish, MI 48658

**Forms**

Quantity: 500  
 Paragon Dept No: 69800  
 Dept Name: McLaren Standish Family Medicine  
 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: _____ CLASS: _____ PHON: _____ BIRTH: _____ SEX: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ TELEPHONE: _____ FAX: _____ BIRTH DATE: _____ 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: _____ For appointment reminders only, use phone number _____ and E-mail _____ For mailing & message, use phone number _____	SPECIALTY: _____ A Family _____ A Internal _____ A General _____ A Pediatrics _____ A Geriatrics _____ A Gynecology _____ A Obstetrics _____ A Ophthalmology _____ A Otolaryngology _____ A Orthopedics _____ A Radiology _____ A Cardiology _____ A Neurology _____ A Psychiatry _____ A Pulmonary _____ A Rheumatology _____ A Dermatology _____ A Endocrinology _____ A Nephrology _____ A Gastroenterology _____ A Hepatology _____ A Infectious Disease _____ A Allergy _____ A Immunology _____ A Hematology _____ A Oncology _____ A Pathology _____ A Radiology _____ A Other _____	SPECIALTY: _____ A Family _____ A Internal _____ A General _____ A Pediatrics _____ A Geriatrics _____ A Gynecology _____ A Obstetrics _____ A Ophthalmology _____ A Otolaryngology _____ A Orthopedics _____ A Radiology _____ A Cardiology _____ A Neurology _____ A Psychiatry _____ A Pulmonary _____ A Rheumatology _____ A Dermatology _____ A Endocrinology _____ A Nephrology _____ A Gastroenterology _____ A Hepatology _____ A Infectious Disease _____ A Allergy _____ A Immunology _____ A Hematology _____ A Oncology _____ A Pathology _____ A Radiology _____ A Other _____
	NAME: _____ CLASS: _____ PHON: _____ BIRTH: _____ RELATIONSHIP: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ EMPLOYER: _____ OCCUPATION: _____ HOW LONG EMPLOYED: _____ EMPLOYER TELEPHONE: _____ EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____		
	PRIMARY INSURANCE: _____ SUBSCRIBER: _____ BIRTH DATE: _____ POLICY # _____ GROUP # _____ EMPLOYEE CATEGORIES: _____ GROUP NAME: _____ SECONDARY INSURANCE: _____ SUBSCRIBER: _____ BIRTH DATE: _____ POLICY # _____ GROUP # _____ EMPLOYEE CATEGORIES: _____ GROUP NAME: _____		
	NEAREST RELATIVE NOT RESIDING AT SAME ADDRESS NAME: _____ RELATIONSHIP: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ HOME TELEPHONE: _____ HOME TELEPHONE: _____ EMERGENCY CONTACT: _____ RELATIONSHIP: _____ TELEPHONE: _____		
REFERENTIAL SIGNATURE: _____ DATE: _____ SIGNATURE: _____ DATE: _____ SIGNATURE: _____ DATE: _____			