

## McLaren Print System Order

Order No: 82134 Reprint Previous Order No: 5523  
 Order Date: 2024-01-05  
 User: Teresa Wenzlick  
 Phone: 9897795692

Ship Location: McLaren Pulmonology - Attn: Chelesy  
 1201 South Drive, Suite 371  
 Mt. Pleasant, MI 48858

### Forms

Quantity: 500  
 Paragon Dept No: 50710  
 Dept Name: Mt. Pleasant  
 Company Number: 810

Order Total Price: 16.75

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: _____ BRNCH: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ TELEPHONE: _____ FAX: _____ CELL PHONE: _____ E-MAIL ADDRESS: _____ EMPLOYER: _____ OCCUPATION: _____ EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ EMPLOYER TELEPHONE: _____ PRESENT CARE PROVIDER: _____ REFERRED OR RECOMMENDED BY: _____	SPECIALTY: _____ A. Family B. Internal C. General D. Pediatric E. Geriatric F. Gynecology G. Obstetrics H. Pediatrics I. Cardiology J. Endocrinology K. Gastroenterology L. Hematology M. Infectious Disease N. Internal Medicine O. Neurology P. Nephrology Q. Oncology R. Orthopedics S. Otolaryngology T. Pathology U. Radiology V. Urology W. Dermatology X. Ophthalmology Y. Plastic Surgery Z. Other: _____		
	For appointment reminders only, use phone number _____ and E-mail _____ For mailing & message, use phone number _____			
	SPOUSE / LEGAL GUARDIAN INFORMATION	NAME: _____ CLASS: _____ PHON: _____ BRNCH: _____ RELATIONSHIP: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ EMPLOYER: _____ OCCUPATION: _____ EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____	HOW LONG EMPLOYED: _____ EMPLOYER TELEPHONE: _____	
		PRESENT INSURANCE: _____ SUBSCRIBER: _____ BIRTH DATE: _____ POLICY # _____ GROUP # _____ EMPLOYEE ORGANIZATION: _____ GROUP NAME: _____ SECONDARY INSURANCE: _____ SUBSCRIBER: _____ BIRTH DATE: _____ POLICY # _____ GROUP # _____ EMPLOYEE ORGANIZATION: _____ GROUP NAME: _____		
OTHER INFORMATION	NEAREST RELATIVE NOT RESIDING AT SAME ADDRESS NAME: _____ RELATIONSHIP: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ HOME TELEPHONE: _____ HOME TELEPHONE: _____ EMERGENCY CONTACT: _____ RELATIONSHIP: _____ TELEPHONE: _____			
	REFERRING PHYSICIAN SIGNATURE: _____ DATE: _____ SIGNATURE: _____ DATE: _____ SIGNATURE: _____ DATE: _____			