

**McLaren Print System Order**

Order No: 82535 Reprint Previous Order No: 5523  
 Order Date: 2024-01-22  
 User: Teresa Wenzlick  
 Phone: 989-779-5222

Ship Location: McLaren ReadyCare - Attn: Brenda  
 1523 S. Mission St.  
 Mt. Pleasant, MI 48858

**Forms**

Quantity: 500  
 Paragon Dept No: 55802  
 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: _____	SPECIALTY: _____ A. Family B. Internal C. General D. Pediatric E. Geriatric F. Gynecology G. Obstetrics H. Pediatrics I. Psychiatry J. Radiology K. Surgery L. Other (Specify)	SEX: _____ A. Male B. Female RACE: _____ A. White B. Black C. Hispanic D. Asian E. Other (Specify)
	PRESENT DATE: _____ REFERRED OR RECOMMENDED BY: _____ For appointment reminders only, use phone number _____ and E-mail _____ For texting & message, use phone number _____		
	NAME: _____ CLASS: _____ PHON: _____ BRNCH: _____ RELATIONSHIP: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ EMPLOYER: _____ OCCUPATION: _____ 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: _____		
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: _____		