

McLaren Print System Order

Order No: 91270
 Order Date: 2025-01-07
 Order Request Date:
 User: STEPHANIE BENDER
 Phone: 2314877200

Ship Location: McLaren Gaylord Family Practice
 1320 M-32 East
 Gaylord, MI 49735

Brochures
 Quantity: 500
 Paragon Dept No: 50684
 Dept Name: McLaren Gaylord Family Practice
 Company Number:

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
 Poster:
 Misc Info:

McLAREN MEDICAL GROUP
 ADULT REGISTRATION

Language Preference: English
 Other specify:

PATIENT INFORMATION

| | | | | | | | | | | | | | | | |
|---------------------|------|----------------------------|------------|-------------------|----------|--------------------|--------|--------|------|------|----------|-----------|---------|-----------|---------------------|
| NAME | LAST | FIRST | MIDDLE | INITIALS | DOB | SEX | HEIGHT | WEIGHT | HAIR | EYES | RELIGION | ALLERGIES | DIETARY | PHYSICIAN | PHYSICIAN TELEPHONE |
| ADDRESS | | CITY | | STATE | ZIP CODE | | | | | | | | | | |
| TELEPHONE | HOME | WORK | CELL PHONE | | | | | | | | | | | | |
| CALL PHONE | | 4 DIGIT ADDRESS | | | | | | | | | | | | | |
| EMPLOYER | | OCCUPATION | | HOW LONG EMPLOYED | | EMPLOYER TELEPHONE | | | | | | | | | |
| EMPLOYER ADDRESS | | CITY | | STATE | ZIP CODE | | | | | | | | | | |
| PHYSICIAN LAST NAME | | REFERRED OR RECOMMENDED BY | | | | | | | | | | | | | |

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

For texting a message, use phone number _____

SPOUSE/LEGAL GUARDIAN INFORMATION

| | | | | | |
|------------------|------|-----------------|------------|-------------------|----------|
| NAME | LAST | FIRST | MIDDLE | RELATIONSHIP | |
| ADDRESS | | CITY | | STATE | ZIP CODE |
| TELEPHONE | HOME | WORK | CELL PHONE | | |
| CALL PHONE | | 4 DIGIT ADDRESS | | | |
| EMPLOYER | | OCCUPATION | | HOW LONG EMPLOYED | |
| EMPLOYER ADDRESS | | CITY | | STATE | ZIP CODE |

INSURANCE INFORMATION

| | | | | |
|---------------------|------------|-------------------|------------|------------|
| PRIMARY INSURANCE | SUBSCRIBER | | EMPLOYEE | GROUP NAME |
| RELAY # | GROUP # | EMPLOYEE CATERING | GROUP NAME | |
| SECONDARY INSURANCE | SUBSCRIBER | | EMPLOYEE | GROUP NAME |
| RELAY # | GROUP # | EMPLOYEE CATERING | GROUP NAME | |

NEAREST RELATIVE NOT RESIDING AT SAME ADDRESS

| | | |
|-------------------|----------------|-----------|
| NAME | RELATIONSHIP | |
| ADDRESS | | |
| CITY | STATE | ZIP CODE |
| HOME TELEPHONE | WORK TELEPHONE | |
| EMERGENCY CONTACT | RELATIONSHIP | TELEPHONE |

PHYSICIAN SIGNATURE

| | |
|-----------|------|
| SIGNATURE | DATE |
| SIGNATURE | DATE |

UPDATES

ADULT REGISTRATION

Spec Info: Original Poster Size