

## McLaren Print System Order

Order No: 41890 Reprint Previous Order No: 5523  
 Order Date: 2019-01-11  
 User: Jessica Smith  
 Phone: 989-773-1166

Ship Location: McLaren Central ReadyCare/ attn: Jessica  
 1523 S. Mission St.  
 Mt. Pleasant , Mi 48858

### Forms

Quantity: 500  
 Paragon Dept No: 75400  
 Dept Name: Central ReadyCare  
 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	<table border="1"> <tr> <td>PERSON NAME</td> <td>LAST</td> <td>FIRST</td> <td>MIDDLE</td> <td>INITIAL</td> <td>STREET</td> <td>CITY</td> <td>STATE</td> <td>ZIP CODE</td> </tr> <tr> <td>TELEPHONE</td> <td>HOME</td> <td>WORK</td> <td>CELL</td> <td>TELEPHONE</td> <td>TELEPHONE</td> <td>TELEPHONE</td> <td>TELEPHONE</td> </tr> <tr> <td>ADDRESS</td> <td>CITY</td> <td>STATE</td> <td>ZIP CODE</td> <td colspan="4"></td> </tr> <tr> <td>EMPLOYER</td> <td>OCCUPATION</td> <td>HOW LONG EMPLOYED</td> <td>EMPLOYER TELEPHONE</td> <td colspan="4"></td> </tr> </table>	PERSON NAME	LAST	FIRST	MIDDLE	INITIAL	STREET	CITY	STATE	ZIP CODE	TELEPHONE	HOME	WORK	CELL	TELEPHONE	TELEPHONE	TELEPHONE	TELEPHONE	ADDRESS	CITY	STATE	ZIP CODE					EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	EMPLOYER TELEPHONE					<table border="1"> <tr> <td> <input type="checkbox"/> English  <input type="checkbox"/> Spanish  <input type="checkbox"/> Vietnamese  <input type="checkbox"/> Chinese  <input type="checkbox"/> Tagalog  <input type="checkbox"/> Hindi  <input type="checkbox"/> Urdu  <input type="checkbox"/> Bengali  <input type="checkbox"/> Gujarati  <input type="checkbox"/> Punjabi  <input type="checkbox"/> Korean  <input type="checkbox"/> Japanese  <input type="checkbox"/> Arabic  <input type="checkbox"/> Russian  <input type="checkbox"/> Polish  <input type="checkbox"/> Portuguese  <input type="checkbox"/> Italian  <input type="checkbox"/> French  <input type="checkbox"/> German  <input type="checkbox"/> Dutch  <input type="checkbox"/> Swedish  <input type="checkbox"/> Norwegian  <input type="checkbox"/> Danish  <input type="checkbox"/> Finnish  <input type="checkbox"/> Czech  <input type="checkbox"/> Slovak  <input type="checkbox"/> Hungarian  <input type="checkbox"/> Romanian  <input type="checkbox"/> Bulgarian  <input type="checkbox"/> Greek  <input type="checkbox"/> Turkish  <input type="checkbox"/> Persian  <input type="checkbox"/> Hebrew  <input type="checkbox"/> Thai  <input type="checkbox"/> Vietnamese  <input type="checkbox"/> Chinese  <input type="checkbox"/> Tagalog  <input type="checkbox"/> Hindi  <input type="checkbox"/> Urdu  <input type="checkbox"/> Bengali  <input type="checkbox"/> Gujarati  <input type="checkbox"/> Punjabi  <input type="checkbox"/> Korean  <input type="checkbox"/> Japanese  <input type="checkbox"/> Arabic  <input type="checkbox"/> Russian  <input type="checkbox"/> Polish  <input type="checkbox"/> Portuguese  <input type="checkbox"/> Italian  <input type="checkbox"/> French  <input type="checkbox"/> German  <input type="checkbox"/> Dutch  <input type="checkbox"/> Swedish  <input type="checkbox"/> Norwegian  <input type="checkbox"/> Danish  <input type="checkbox"/> Finnish  <input type="checkbox"/> Czech  <input type="checkbox"/> Slovak  <input type="checkbox"/> Hungarian  <input type="checkbox"/> Romanian  <input type="checkbox"/> Bulgarian  <input type="checkbox"/> Greek  <input type="checkbox"/> Turkish  <input type="checkbox"/> Persian  <input type="checkbox"/> Hebrew  <input type="checkbox"/> Thai                 </td> <td> <input type="checkbox"/> Male  <input type="checkbox"/> Female  <input type="checkbox"/> Other                 </td> </tr> </table>	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Hindi <input type="checkbox"/> Urdu <input type="checkbox"/> Bengali <input type="checkbox"/> Gujarati <input type="checkbox"/> Punjabi <input type="checkbox"/> Korean <input type="checkbox"/> Japanese <input type="checkbox"/> Arabic <input type="checkbox"/> Russian <input type="checkbox"/> Polish <input type="checkbox"/> Portuguese <input type="checkbox"/> Italian <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Dutch <input type="checkbox"/> Swedish <input type="checkbox"/> Norwegian <input type="checkbox"/> Danish <input type="checkbox"/> Finnish <input type="checkbox"/> Czech <input type="checkbox"/> Slovak <input type="checkbox"/> Hungarian <input type="checkbox"/> Romanian <input type="checkbox"/> Bulgarian <input type="checkbox"/> Greek <input type="checkbox"/> Turkish <input type="checkbox"/> Persian <input type="checkbox"/> Hebrew <input type="checkbox"/> Thai <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Hindi <input type="checkbox"/> Urdu <input type="checkbox"/> Bengali <input type="checkbox"/> Gujarati <input type="checkbox"/> Punjabi <input type="checkbox"/> Korean <input type="checkbox"/> Japanese <input type="checkbox"/> Arabic <input type="checkbox"/> Russian <input type="checkbox"/> Polish <input type="checkbox"/> Portuguese <input type="checkbox"/> Italian <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Dutch <input type="checkbox"/> Swedish <input type="checkbox"/> Norwegian <input type="checkbox"/> Danish <input type="checkbox"/> Finnish <input type="checkbox"/> Czech <input type="checkbox"/> Slovak <input type="checkbox"/> Hungarian <input type="checkbox"/> Romanian <input type="checkbox"/> Bulgarian <input type="checkbox"/> Greek <input type="checkbox"/> Turkish <input type="checkbox"/> Persian <input type="checkbox"/> Hebrew <input type="checkbox"/> Thai	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
	PERSON NAME	LAST	FIRST	MIDDLE	INITIAL	STREET	CITY	STATE	ZIP CODE																												
	TELEPHONE	HOME	WORK	CELL	TELEPHONE	TELEPHONE	TELEPHONE	TELEPHONE																													
	ADDRESS	CITY	STATE	ZIP CODE																																	
EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	EMPLOYER TELEPHONE																																		
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Hindi <input type="checkbox"/> Urdu <input type="checkbox"/> Bengali <input type="checkbox"/> Gujarati <input type="checkbox"/> Punjabi <input type="checkbox"/> Korean <input type="checkbox"/> Japanese <input type="checkbox"/> Arabic <input type="checkbox"/> Russian <input type="checkbox"/> Polish <input type="checkbox"/> Portuguese <input type="checkbox"/> Italian <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Dutch <input type="checkbox"/> Swedish <input type="checkbox"/> Norwegian <input type="checkbox"/> Danish <input type="checkbox"/> Finnish <input type="checkbox"/> Czech <input type="checkbox"/> Slovak <input type="checkbox"/> Hungarian <input type="checkbox"/> Romanian <input type="checkbox"/> Bulgarian <input type="checkbox"/> Greek <input type="checkbox"/> Turkish <input type="checkbox"/> Persian <input type="checkbox"/> Hebrew <input type="checkbox"/> Thai <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Tagalog <input type="checkbox"/> Hindi <input type="checkbox"/> Urdu <input type="checkbox"/> Bengali <input type="checkbox"/> Gujarati <input type="checkbox"/> Punjabi <input type="checkbox"/> Korean <input type="checkbox"/> Japanese <input type="checkbox"/> Arabic <input type="checkbox"/> Russian <input type="checkbox"/> Polish <input type="checkbox"/> Portuguese <input type="checkbox"/> Italian <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Dutch <input type="checkbox"/> Swedish <input type="checkbox"/> Norwegian <input type="checkbox"/> Danish <input type="checkbox"/> Finnish <input type="checkbox"/> Czech <input type="checkbox"/> Slovak <input type="checkbox"/> Hungarian <input type="checkbox"/> Romanian <input type="checkbox"/> Bulgarian <input type="checkbox"/> Greek <input type="checkbox"/> Turkish <input type="checkbox"/> Persian <input type="checkbox"/> Hebrew <input type="checkbox"/> Thai	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other																																				
<table border="1"> <tr> <td> <input type="checkbox"/> For appointment reminders only, use phone number and E-mail  <input type="checkbox"/> For mailing &amp; message, use phone number                 </td> <td> <input type="checkbox"/> Yes  <input type="checkbox"/> No                 </td> </tr> </table>	<input type="checkbox"/> For appointment reminders only, use phone number and E-mail <input type="checkbox"/> For mailing & message, use phone number	<input type="checkbox"/> Yes <input type="checkbox"/> No																																			
<input type="checkbox"/> For appointment reminders only, use phone number and E-mail <input type="checkbox"/> For mailing & message, use phone number	<input type="checkbox"/> Yes <input type="checkbox"/> No																																				
<table border="1"> <tr> <td> <input type="checkbox"/> Primary Insurance  <input type="checkbox"/> Secondary Insurance                 </td> <td> <input type="checkbox"/> Subscriber  <input type="checkbox"/> Employee (ORGANIZED)  <input type="checkbox"/> GROUP NAME                 </td> <td> <input type="checkbox"/> BIRTH DATE                 </td> </tr> </table>	<input type="checkbox"/> Primary Insurance <input type="checkbox"/> Secondary Insurance	<input type="checkbox"/> Subscriber <input type="checkbox"/> Employee (ORGANIZED) <input type="checkbox"/> GROUP NAME	<input type="checkbox"/> BIRTH DATE																																		
<input type="checkbox"/> Primary Insurance <input type="checkbox"/> Secondary Insurance	<input type="checkbox"/> Subscriber <input type="checkbox"/> Employee (ORGANIZED) <input type="checkbox"/> GROUP NAME	<input type="checkbox"/> BIRTH DATE																																			
<table border="1"> <tr> <td> <input type="checkbox"/> Primary Insurance  <input type="checkbox"/> Secondary Insurance                 </td> <td> <input type="checkbox"/> Subscriber  <input type="checkbox"/> Employee (ORGANIZED)  <input type="checkbox"/> GROUP NAME                 </td> <td> <input type="checkbox"/> BIRTH DATE                 </td> </tr> </table>	<input type="checkbox"/> Primary Insurance <input type="checkbox"/> Secondary Insurance	<input type="checkbox"/> Subscriber <input type="checkbox"/> Employee (ORGANIZED) <input type="checkbox"/> GROUP NAME	<input type="checkbox"/> BIRTH DATE																																		
<input type="checkbox"/> Primary Insurance <input type="checkbox"/> Secondary Insurance	<input type="checkbox"/> Subscriber <input type="checkbox"/> Employee (ORGANIZED) <input type="checkbox"/> GROUP NAME	<input type="checkbox"/> BIRTH DATE																																			
NEAREST RELATIVE NOT RESIDING AT SAME ADDRESS	<table border="1"> <tr> <td>NAME</td> <td>RELATIONSHIP</td> </tr> <tr> <td>ADDRESS</td> <td>CITY</td> <td>STATE</td> <td>ZIP CODE</td> </tr> <tr> <td>HOME TELEPHONE</td> <td>WORK TELEPHONE</td> <td>TELEPHONE</td> <td>TELEPHONE</td> </tr> <tr> <td>EMERGENCY CONTACT</td> <td>RELATIONSHIP</td> <td>TELEPHONE</td> <td>TELEPHONE</td> </tr> </table>	NAME	RELATIONSHIP	ADDRESS	CITY	STATE	ZIP CODE	HOME TELEPHONE	WORK TELEPHONE	TELEPHONE	TELEPHONE	EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE	TELEPHONE																						
	NAME	RELATIONSHIP																																			
ADDRESS	CITY	STATE	ZIP CODE																																		
HOME TELEPHONE	WORK TELEPHONE	TELEPHONE	TELEPHONE																																		
EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE	TELEPHONE																																		
<table border="1"> <tr> <td> <input type="checkbox"/> REFERRING PHYSICIAN SIGNATURE  <input type="checkbox"/> DATE                 </td> <td> <input type="checkbox"/> SIGNATURE  <input type="checkbox"/> DATE                 </td> </tr> </table>	<input type="checkbox"/> REFERRING PHYSICIAN SIGNATURE <input type="checkbox"/> DATE	<input type="checkbox"/> SIGNATURE <input type="checkbox"/> DATE																																			
<input type="checkbox"/> REFERRING PHYSICIAN SIGNATURE <input type="checkbox"/> DATE	<input type="checkbox"/> SIGNATURE <input type="checkbox"/> DATE																																				

ADULT REGISTRATION