

**McLaren Print System Order**

Order No: 42840 Reprint Previous Order No: 5523  
 Order Date: 2019-02-12  
 User: Diana Garver  
 Phone: 989-386-8170

Ship Location: McLaren Central - Clare Clinic - Attn: Jeanette  
 1509 N McEwan  
 Clare, MI 48617

**Forms**

Quantity: 500  
 Paragon Dept No: 75075  
 Dept Name: Clare Clinic  
 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>STATUS</td> <td>MR</td> <td>MS</td> <td>DR</td> <td>OTHER</td> </tr> <tr> <td>ADDRESS</td> <td>CITY</td> <td>STATE</td> <td>ZIP CODE</td> <td> <input type="checkbox"/> HOME  <input type="checkbox"/> WORK  <input type="checkbox"/> OTHER                 </td> <td> <input type="checkbox"/> MARRIED  <input type="checkbox"/> SINGLE  <input type="checkbox"/> DIVORCED  <input type="checkbox"/> SEPARATED  <input type="checkbox"/> WIDOWED  <input type="checkbox"/> OTHER                 </td> <td> <input type="checkbox"/> YES  <input type="checkbox"/> NO                 </td> <td> <input type="checkbox"/> YES  <input type="checkbox"/> NO                 </td> </tr> <tr> <td>TELEPHONE</td> <td>EXT</td> <td>BIRTH DATE</td> <td> <input type="checkbox"/> YES  <input type="checkbox"/> NO                 </td> <td> <input type="checkbox"/> YES  <input type="checkbox"/> NO                 </td> <td> <input type="checkbox"/> YES  <input type="checkbox"/> NO                 </td> <td> <input type="checkbox"/> YES  <input type="checkbox"/> NO                 </td> <td> <input type="checkbox"/> YES  <input type="checkbox"/> NO                 </td> </tr> <tr> <td>LAST PHONE</td> <td colspan="2">E MAIL ADDRESS</td> <td> <input type="checkbox"/> YES  <input type="checkbox"/> NO                 </td> <td> <input type="checkbox"/> YES  <input type="checkbox"/> NO                 </td> <td> <input type="checkbox"/> YES  <input type="checkbox"/> NO                 </td> <td> <input type="checkbox"/> YES  <input type="checkbox"/> NO                 </td> <td> <input type="checkbox"/> YES  <input type="checkbox"/> NO                 </td> </tr> </table>	PERSON NAME	LAST	FIRST	MIDDLE	INITIAL	STATUS	MR	MS	DR	OTHER	ADDRESS	CITY	STATE	ZIP CODE	<input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> OTHER	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OTHER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	TELEPHONE	EXT	BIRTH DATE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	LAST PHONE	E MAIL ADDRESS		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<table border="1"> <tr> <td>EMPLOYER</td> <td>OCCUPATION</td> <td>HOW LONG EMPLOYED</td> <td>EMPLOYER TELEPHONE</td> </tr> <tr> <td>EMPLOYER ADDRESS</td> <td>CITY</td> <td>STATE</td> <td>ZIP CODE</td> </tr> <tr> <td>PRESENT CARE PROVIDER</td> <td colspan="3">REFERRED OR RECOMMENDED BY</td> </tr> </table>	EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	EMPLOYER TELEPHONE	EMPLOYER ADDRESS	CITY	STATE	ZIP CODE	PRESENT CARE PROVIDER	REFERRED OR RECOMMENDED BY		
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