

## McLaren Print System Order

Order No: 42862 Reprint Previous Order No: 5523  
 Order Date: 2019-02-13  
 User: Dolores Guy  
 Phone: Dodge Park

Ship Location: Dolores Guy  
 35111 Dodge Park  
 Sterling Heights, MI 48312

### Forms

Quantity: 500  
 Paragon Dept No: 72500  
 Dept Name: McLaren Pediatrics  
 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	PREFIX NAME: _____ CLASS: _____ PHON: _____ BIRTH: _____ SEX: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ TELEPHONE: _____ FAX: _____ BIRTH DATE: _____ CELL PHONE: _____ E-MAIL ADDRESS: _____ EMPLOYER: _____ OCCUPATION: _____ HOW LONG EMPLOYED: _____ EMPLOYER TELEPHONE: _____ EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ PRESENT CARE PROVIDER: _____ REFERRED OR RECOMMENDED BY: _____	<input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Japanese <input type="checkbox"/> Other: _____ <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"/> Arabic <input type="checkbox"/> Persian <input type="checkbox"/> Russian <input type="checkbox"/> Polish <input type="checkbox"/> Czech <input type="checkbox"/> Slovak <input type="checkbox"/> Croatian <input type="checkbox"/> Serbian <input type="checkbox"/> Slovenian <input type="checkbox"/> Romanian <input type="checkbox"/> Bulgarian <input type="checkbox"/> Greek <input type="checkbox"/> Turkish <input type="checkbox"/> Italian <input type="checkbox"/> Portuguese <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Dutch <input type="checkbox"/> Danish <input type="checkbox"/> Swedish <input type="checkbox"/> Norwegian <input type="checkbox"/> Finnish <input type="checkbox"/> Estonian <input type="checkbox"/> Latvian <input type="checkbox"/> Lithuanian <input type="checkbox"/> Czech <input type="checkbox"/> Slovak <input type="checkbox"/> Hungarian <input type="checkbox"/> Polish <input type="checkbox"/> Czech <input type="checkbox"/> Slovak <input type="checkbox"/> Croatian <input type="checkbox"/> Serbian <input type="checkbox"/> Slovenian <input type="checkbox"/> Romanian <input type="checkbox"/> Bulgarian <input type="checkbox"/> Greek <input type="checkbox"/> Turkish <input type="checkbox"/> Italian <input type="checkbox"/> Portuguese <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Dutch <input type="checkbox"/> Danish <input type="checkbox"/> Swedish <input type="checkbox"/> Norwegian <input type="checkbox"/> Finnish <input type="checkbox"/> Estonian <input type="checkbox"/> Latvian <input type="checkbox"/> Lithuanian		
	For appointment reminders only, use phone number _____ and E-mail _____ For texting & messages, use phone number _____			
	SPOUSE / LEGAL GUARDIAN INFORMATION	NAME: _____ CLASS: _____ PHON: _____ BIRTH: _____ RELATIONSHIP: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____ EMPLOYER: _____ OCCUPATION: _____ HOW LONG EMPLOYED: _____ EMPLOYER TELEPHONE: _____ EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____		
		PRIMARY 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: _____			