McLaren

PORT HURON

Event Mail-In Registration Form

First Name

_____

Last Name

_____

Address 1 _____
Address 2 _____
City_____
State_____ Zip _____
Home Telephone _____
Work Telephone _____
Fax Number _____
Email _____

Do you have Medicaid? _____ Yes _____ No
Insurance Name_____
Date of birth (aids registration) _____

Women's Wellness Place Member ___ 55 Plus Member ___

Program name _____ Date_____ Fee _____
Program name _____ Date_____ Fee _____
Total $_____

Payment Information:

___Check Amount: $_____ Visa ___ MasterCard ___ Discover ___

Name on Credit Card: _____
Credit Card Number: _____

Expiration Date _____ Security Code _____ (Visa, MasterCard, or Discover - This is a 3 digit number found on the back of the card.)

Complete one form per person, **make checks payable to McLaren Port Huron,** and mail to: McLaren Port Huron, Attn: HealthAccess, P.O. Box 5011, Port Huron, MI 48060-5011.