Please print this form from the web site and mail or fax it to Hastings Internal Medicine

HASTINGS
INTERNAL MEDICINE *Health Care for Adults*

Getting to know you…

Thank you for your interest in Hastings Internal Medicine, a "Patient-Centered Medical Home." Our staff is committed to providing quality personal service to all of our patients. Hastings Internal Medicine does not discriminate on the basis of age, race, gender or medical insurance, although we do not participate with all insurance plans. We do not accept patients under the age of 18.

Please answer the questions on the following page to let us know more about you. Completion of this and the registration form does *not* guarantee acceptance into the practice, and does *not* create a physician-patient relationship. Information you provide will be shared only with your permission.

We are looking forward to serving you! Your first appointment will be a "get acquainted" visit to complete your medical record and identify your health needs. You will meet with either the midlevel provider (physician assistant or nurse practitioner) or the physician.

Pharmacy checks are completed on all new patients to verify prescriptions of controlled medications.

If you need help completing this form, notify one of our staff and we will assist you by phone or in person at Hastings Internal Medicine

1005 West Green Street, Suite 202, Hastings, Michigan 49058
Telephone (269) 948-0078, Fax (269) 948-0099
www.HastingsIM.com

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Name: _____ Today's date: _____

How did you find out about Hastings Internal Medicine?

_____

Why are you looking for a new medical provider?

_____

How many times have you visited the emergency department in the past 12 months?

_____

List the names of all doctors including specialists that you have seen in the past 12 months:

_____ _____

_____ _____

List your medications and doses – (include all prescriptions, over-the-counter meds and supplements):

_____ _____

_____ _____

_____ _____

_____ _____

List your current health conditions

_____

_____

_____

_____

_____

List previous surgeries, with approximate dates

_____

_____

_____

_____

_____

Who assists you with your health care needs (if anyone): _____

Do you smoke Cigarettes or Cigars?_____ Do you chew Tobacco?_____

If there was one most important health problem we could help you with, what would it be?

_____

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Patient Registration – Hastings Internal Medicine

Patient Name	Date of Birth	Social Security Number
Address		City, State and Zip
Home Phone	Work Phone	Cell Phone
Email Address		

Marital status (please circle): Single Married Separated Divorced Widowed

Patient's Employer	Employer's address

Primary Insurance Name	
Policy Holder Name	Date of Birth
Contract #	Group #

Secondary Insurance Name	
Policy Holder Name	Date of Birth
Contract #	Group #

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I authorize my insurance plan to pay and hereby assign benefits to be paid to my physician all benefits. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received will be credited to my account in accordance with the above assignment.

Patient signature: _____ Date: _____

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