



## *Getting to know you...*

Thank you for your interest in Hastings Internal and Family Medicine, a “Patient-Centered Medical Home.” We are committed to providing quality personal service to all of our patients. Hastings Internal and Family Medicine does not discriminate on the basis of age, race, gender or medical insurance, although we do not participate with all insurance plans.

---

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.

---

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

---

If you need help completing this form, notify any of our staff and we will be happy to assist you.

# General information

Name: \_\_\_\_\_ Today's date: \_\_\_\_\_ Date of birth: \_\_\_\_\_

---

---

Who referred you to Hastings Internal and Family Medicine?

\_\_\_\_\_

Why are you looking for a new medical provider?

\_\_\_\_\_

How many times have you been to the ER in the past 12 months? \_\_\_\_\_

When was your last annual physical? \_\_\_\_\_

List the all medical providers you have seen in the past 12 months:

Primary provider:

Specialists:

\_\_\_\_\_

\_\_\_\_\_

Hospitals:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List your current health problems:

Previous surgeries, with approximate dates:

---

---

---

---

---

---

---

---

---

---

---

---

---

---

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

---

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

---

### Insurance and registration information:

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Primary Insurance Name \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance Name \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_