PARKWAY
PRIMARY • CARE

Shane E. Keller, M.D. • Tina J. Philip, D.O. • Ann-Marie Koch, FNP
505 W. Louis Henna Blvd., Ste. 100 Austin, TX 78728
Phone: 512.252.1505 • Fax: 512.252.1506 • www.parkwayprimarycare.com

**NEW PATIENT INFORMATION**
*****All sections MUST be completed. If not applicable, please indicate as "NA"*****

Last Name_____ First Name_____ M.I_____

Sex_____ SSN_____ Marital Status S M W D Birth Date_____/_____/_____ Age_____

Mailing Address _____
Address Apt# City State Zip

**How may we contact you?**
☐ Home Phone#_____
☐ Cell Phone#_____
☐ Work Phone#_____
☐ E-Mail_____

Which of the above is your preferred method of contact? _____

Driver's License/State_____

Employer /School Name_____

**INSURANCE** **Do you have Insurance?** ☐ Yes ☐ No *If yes, please complete section below, if no please skip to Pharmacy info

Guarantor/Employee's Name_____ Employer_____

Sex_____ Birth Date_____/_____/_____ SSN_____ Pt's Relationship to Insured_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Insurance Co Name_____ Phone# _____

Subscriber/Member ID#_____ Group#_____

**Do you have secondary insurance?** ☐ Yes ☐ No *If yes, please complete section below, if not skip to Pharmacy info

Guarantor/Employee's Name_____ Employer_____

Sex_____ Birth Date_____/_____/_____ SSN_____ Pt's Relationship to Insured_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Insurance Co Name_____ Phone# _____

Subscriber/Member ID#_____ Group#_____

**What Pharmacy Do You Use?**_____
Name Street Phone#

**EMERGENCY CONTACT**

1ST Name_____ Phone#_____ Relationship_____

2nd Name_____ Phone#_____ Relationship_____

**REFERRED BY**

Internet Community Impact Family/Friend HMO/PPO Directory Hospital Yellow Pgs

Employee Current Patient; Name: _____ Physician; Name: _____

**CONSENT FOR TREATMENT**: *I hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.*

**Date**_____ **Signature** (patient/guardian)_____ **Relationship**_____

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**Release of Medical Records**
**(If you wish us to obtain your medical records from another provider, please complete this form)**

Name of Patient: _____

DOB: _____ Social Security Number: _____

I authorize the release of my protected medical records as requested below:

☐ **To** ☐ **From** Parkway Primary Care
505 W. Louis Henna Blvd., Ste. 100
Austin, TX 78728
Phone # (512)252-1505 Fax# (512)252-1506

**Attention:** ☐ **Shane E. Keller, MD** ☐ **Tina J. Philip, DO** ☐ **Ann Marie Koch, FNP**

☐ **To** ☐ **From** _____

_____

_____

Phone#: _____

Fax#: _____

Are you transferring care? YES NO

**Dates Requested: *Last 2 Years only* unless otherwise specified below:**

**From:** _____ **To:** _____

*Information to be released: (Reports may include information on drug / alcohol / psychological / HIV or communicable disease treatment.)*

**Records requested:**

☐ History & Physical ☐ Consultations ☐ EKG ☐ HIV/AIDS ☐ Progress Notes
☐ Laboratory ☐ Radiology/MRI/CT ☐ Other ☐ All Medical Records

**Purpose for release of information:**

☐ Personal Use ☐ Legal Purposes ☐ Insurance ☐ Continuing Medical Care
☐ Social Security/ Disability ☐ Other

I understand that I may revoke this consent anytime except to the extent that action has already been made before receipt of revocation. This authorization expires automatically one hundred eighty (180) days from the date of signature or as otherwise specified. I understand that I may be charged for copies of my medical records. I understand that these records are protected under federal/ state law and cannot be disclosed without my consent otherwise provided by law. Releasing office will not be responsible for dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer, employer, attorney or other designee.

**Date**_____ **Signature** (patient/guardian)_____

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## Adult Patient History Form

Welcome to Parkway Primary Care and thank you for choosing us as your medical home. Thorough and accurate medical records help us provide you with the best quality medical care. Thank you for taking time to complete this summary.

Patient Name: _____ Date of Birth: _____

### Past Medical History (Circle all that apply):

Heart Disease
Kidney Disease
Asthma & Lung
Liver, Hepatitis
Gastrointestinal
Peptic Ulcer
Head Injury, Seizures
Other (please list):

High Cholesterol, Triglycerides
Migraines
Diabetes
Thyroid or Glandular
Cancer
Back or Spine Disorder
Arthritis

Psychiatric Disorders
High Blood Pressure
Stroke
Retina, Vision, Glaucoma
Colon Disorder
HIV or AIDS
Seasonal Allergies

### Past Surgical History (Circle all that apply):

Cataract
Ear Tubes
Tonsil Removal
Thyroid Removal
Breast Surgery
Heart Surgery
Other (please list):

Hysterectomy (Uterus)
Ovaries removed
Tubal ligation
Vasectomy
Knee Surgery
Hip Surgery

Gall Bladder
Hernia Repair
Fracture Repair
Appendix Removal

**Family History:** Please list any medical problems. If deceased, please indicate age and reason.

| | Relative | Living/Deceased | Age |
|---|---|---|---|
| Stroke | | | |
| Blood Clots | | | |
| Cancer (list type) | | | |
| Heart Problems | | | |
| Diabetes | | | |
| High Blood Pressure | | | |
| Lung Problems | | | |
| High Cholesterol | | | |
| Other | | | |

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Patient Name: _____ Date of Birth: _____

**Medication Allergies**: Please list any medications to which you are allergic and tell us what happened when you took the medication:

**Regular Medications:** Include vitamins, over the counter, birth control, herbal meds
**(Daily & As Needed)** (Example: Zantac, 75mg, 2 x a day)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

**Social Habits:** Please tell us about your social habits. Have you ever consumed any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Alcohol | YES | NO | Drinks per week? | Year Started: | Year Stopped: |
| Tobacco | YES | NO | Packs per day? | | |
| Street Drugs | YES | NO | Type(s)? | | |

**Women:**

Date of last menstrual period: _____
Age of first period: _____

Date of last pap smear: _____
Date of last mammogram: _____
Number of pregnancies: _____
Number of miscarriages or abortions: _____
Number of C-Sections: _____

How many days do your periods last?
Are your periods: Every Month Irregular
If irregular, how many per year? _____
Have you ever had an abnormal pap smear? Yes No
Do you perform breast exams monthly? Yes No
Number of live births: _____
Type of contraception used: _____

**Men:**

Date of last prostate exam: _____

Date of last PSA test: _____

**Everyone:**

Are you sexually active? YES NO
How many partners have you had in the last year?

If yes, are your partners: Men Women Both
Do you use safe sexual practices?

**If known, please list the date of the last time you had the following:**

Tetanus shot:
Flu Shot:
Pneumonia shot:
Shingles Vaccine:
Eye exam:
Cholesterol check:
Colon Cancer Screen:

**Other Physicians:** Please list any physicians you have seen (i.e. prior PCP, Cardiologist, Gastroenterologist, OB/GYN)

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____