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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Adolescent Patient History (11-16 years)

Patient's name: ______________________________ **Date of Birth:** ____________________

Medical History:

1. Have you ever stayed overnight in the hospital? If yes, when and for what problem?
2. Have you ever had an operation? If yes, what was it and when?
3. Do you take any medications? If yes, what and for how long?
4. Do you have any medication allergies?

If you have ever had any of the following problems, please **circle** the problem and write how old you were when it started or when you had it:

AGE	AGE
Acne	Recurring Headaches
Asthma	Any Heart Problems or Heart Murmur
Bladder Infection	Learning Problems
Broken Bones	Recurring Stomach Pain
Chicken Pox	Seizures
Concussion	Scoliosis/Back Problems
Depression	Sprained Ankle
Emotional Problems	Vision Problems
Hearing Problems	

Other Problems:

Family Health Information: Please **circle** the disease if anyone in your child's family (parents, grandparents, brother/sister) has these diseases and write your **child's** relationship to that person.

	Relationship		Relationship
Alcohol Abuse		High Blood Pressure	
Asthma		Kidney Disease	
Cancer		Learning Problems	
High Cholesterol		Mental Illness, Suicide	
Deafness		Seizures	
Adult Onset Diabetes		Stroke	
Childhood Onset Diabetes		Sudden Unexplained Death	
Drug Abuse		Thyroid Disease	
Heart Attack (less than 65 yrs old)		Other Diseases	

Family Information:

With whom do you live? (Mom, Dad, Brothers and Sisters, other people) If split custody, please describe the arrangement.

Have you had any family problems?

Does anyone in your household smoke?