



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



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

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) _____



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

Pediatric Patient History (0-10 Years)

Patient Name: _____ **Date of Birth:** _____

Medical History:

1. Was your child full term or preterm (4 or more weeks early)?
2. Were there any problems during your pregnancy? Did you take any medications during your pregnancy?
3. Did your child have any problems right after birth?
4. Has your child ever stayed overnight in the hospital? If yes, when and for what problem?
5. Has your child ever had an operation? If yes, what was it and when?
6. Has your child taken any long-term medications (more than 2 weeks)? If yes, what? How long was the medication continued?
7. Does your child have any medication allergies?
8. Are your child's immunizations up to date? Please provide us with your child's immunization record.

If your child has ever had any of the following problems, please **circle** the problem and write how old they were when it started or when they had it:

| AGE | AGE |
|------------------------------|-----------------------------------|
| Asthma | Frequent Headaches |
| Bedwetting/Daytime accidents | Any Heart Problem or Heart Murmur |
| Bladder or Kidney Infection | Learning Problems |
| Broken Bones | Problems with Vision or Eyes |
| Chicken Pox | Scoliosis/Back Problems |
| Concussion | Seizures |
| Depression | Skin Problems |
| Diabetes | Sleep Problems |
| Emotional Problems | Second-Hand Smoke Exposure |
| Frequent Ear Infections | Speech Difficulties |
| Hearing Problems | |

Other Problems:



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

Patient Name: _____ **Date of Birth:** _____

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 does your child live? (Mom, Dad, Brothers and Sisters, other people) If split custody, please describe the arrangement.

Have you had any family problems?

Mother's Name: _____ Date of Birth: _____

Father's Name: _____ Date of Birth: _____

Other Guardians or caretakers names: _____

Brothers and Sisters:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Person completing this form: _____ **Relationship to Patient:** _____