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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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?