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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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:

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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:** __________