WELCOME TO THE OFFICE OF DR. DOUGLAS MCKAY DPM, FACFAS

Patient History ****ALL BOLD INFO IS MANDATORY**

Date: _____

**Patient's Name _____**

**Address: _____city_____Zip_____**

**Cell Phone _____ Home Phone_____**

**Date of birth** _____ Marital Status S M W O

Social Security Number: _____

Student? Y N Occupation: _____ Employer:_____

Employer's address & Phone # _____

Spouse, Significant Other or Guardian (if patient is under the age of 18) _____DOB_____

**Tel Number _____ Emergency contact & tel number**

**_____**

**Employer of Insured: _____, city/state_____**

Insured by: _____ ID#_____Grp#_____

**Name of Insured** _____**Birthdate**:_____

Do you have secondary insurance? Y N if so, Ins. Name and ID #_____

What brings you here today? (be specific) _____

When did the issue begin? _____

Have you had treatment for your foot/ankle issue before? Y N by whom? _____

Is this an injury: Y N How did it happen? _____

What is your Height _____ weight _____ Shoe size: _____

Is your overall health: Good Fair Poor

If any, what issued do you have?_____

Current medications incl over the counter:_____

_____

**Pharmacy name/address/number:_____**

**Primary doctor's name and tel number _____Date last seen? _____**

Have you had any surgeries? Y N

If so, what type and when (approx.) _____
_____

Are you pregnant? Y N Are you on a special diet: Y N if so, what is it?_____

Do you smoke Y N Drink alcohol daily? Y N if YES, approx. how much?_____

**Allergies: Y N**

**To:**

_____
_____

Please check if you have had or do have any of the following:

Family history of Diabetes_____ Heart disease _____ High BP?_____

Diabetes yourself _____ Stroke_____ Epilepsy/seizures? _____

Varicose Veins _____ Asthma_____ Kidney disease _____

Liver disease _____ Aids/HIV _____ Hepatitis (any type) _____

TB _____ Rheumatoid arthritis _____ Osteoporosis _____ Arthritis _____

Stomach ulcers _____ digestive issues _____ (what type)_____

Arteriosclerosis _____ Glaucoma _____ Had surgery for it? Y N

Kidney disease _____ Anxiety? _____ Depression _____ Anemia _____

Tumors _____ Gout _____ Cancer _____ if so, what type? _____

Treatment? _____

Is there anything else we should know? _____

I hereby give permission to Dr. McKay to release any info required to my insurance co, my PCP, and to examine and treat me for the issues I present with. I also had the HIPPA forms available to read/copy. I understand my copays are due at the time of my visits, and deductible and coinsurance are my responsibility and must be paid within 30 days of receipt of bill. If my insurance requires a referral, it is my responsibility to obtain one and present prior to being seen by the doctor. Chronic no show appts will be charged for after the 2nd one without notice of cancellation. If I pay by check and it does not clear the bank or bounces, there will be a fee of $35 + original amount due.

Signed: _____ date: _____

Guardian or parent if patient is under 18 yrs old: _____

Printed name: _____

**The best number to reach me at is _____** is it ok to lv a msg? Y N