Orthopaedic Specialists of Dallas
SPORTS MEDICINE • JOINT REPLACEMENT • FOOT/ANKLE SPECIALISTS

M. Umar Burney, MD
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Tel: (972) 771 8111
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www.dallasortho.net

Locations:
1301 Summer Lee Dr., Rockwall, TX 75032
2300 FM 544, Ste 120, Wylie, TX 75098
200 N. Virginia St., Terrell, TX 75160

PATIENT DEMOGRAPHICS

DATE:

PERSONAL INFORMATION

PATIENT NAME:	SS#:	DATE OF BIRTH:
ADDRESS:		ZIP CODE:
HOME #:	MOBILE #:	METHOD OF CONTACT: ☐PHONE ☐MOBILE ☐EMAIL
DL #:	EMAIL:	MARITAL STATUS: ☐M ☐W ☐D ☐S
GENDER: ☐ M ☐ F	RACE:	ETHNICITY:
EMERGENCY CONTACT:	CONTACT #:	RELATION:

PATIENT EMPLOYMENT

EMPLOYER:	OCCUPATION:
EMPLOYER ADDRESS:	WORK #:
EMPLOYER TELEPHONE:	EMPLOYER FAX:

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

NAME:	SS#:	DOB:
ADDRESS:	PHONE #:	RELATIONSHIP:
EMPLOYER:	EMPLOYER TEL:	
FULL EMPLOYER ADDRESS:		

INSURANCE INFORMATION

☐WORKMAN'S COMP ☐GROUP ☐MEDICARE ☐CASH PAY

INSURANCE COMPANY:	
ID#:	GROUP#:
INSURED'S NAME:	INSURED DOB: / /
SECONDARY INS CO:	
SECONDARY INS ID#:	SECONDARY INS GRP#:
INSURED'S NAME:	INSURED DOB: / /

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** ____/____/____

****PLEASE PROVIDE A COPY OF ALL INSURANCE CARDS AND PHOTO ID****

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PATIENT HISTORY

PATIENT NAME: PATIENT AGE: DATE:

REFERRING DOCTOR OR PERSON:_____ FAMILY DOCTOR:_____

ARE YOU RIGHT OR LEFT HANDED?: ☐ RIGHT ☐ LEFT

WHAT IS YOUR CURRENT JOB STATUS?: ☐ WORKING ☐ NOT WORKING ☐ LIGHT DUTY ☐ DISABLED

PLEASE DESCRIBE WHAT KIND OF WORK YOU PHYSICALLY DO:_____

DO YOU EXERCISE?: ☐ YES ☐ NO IF YES HOW MANY TIMES A WEEK:_____

WHAT KIND OF EXERCISE DO YOU DO?:_____

CHIEF COMPLAINT

WHAT ORTHOPAEDIC PROBLEM ARE YOU SEEING THE DOCTOR FOR TODAY? WE NEED TO KNOW YOUR **SPECIFIC COMPLAINT, DATE OF INJURY,** AND **PLACE OF INJURY**:

_____

_____.

IS THIS THE RIGHT OR THE LEFT SIDE?: ☐ RIGHT ☐ LEFT ☐ BOTH

CURRENT PROBLEM IS THE RESULT OF(CHECK ALL THAT APPLY): ☐ CAR ACCIDENT ☐ WORK ☐ ACCIDENT/INJURY ☐ OTHER

DATE OF ACCIDENT OR INJURY:____/____/____ ****EXACT DATE OF INJURY IS REQUIRED** IF YOU DO NOT REMEMBER THE EXACT DATE, PLEASE MARK A DATE THAT IS CLOSE TO THE DATE OF INJURY. ****This date will be used to process your claim. If you do not specify this, your insurance could deny your claim.

PLEASE DESCRIBE:_____

_____

MEDICAL HISTORY

HAVE YOU EVER HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY):

☐ DIABETES ☐ ARTHRITIS ☐ HIGH BLOOD PRESSURE ☐ HEART DISEASE ☐ HEART ATTACK ☐ VASCULAR DISEASES
☐ PACEMAKER/SURGICAL IMPLANTS ☐ HEADACHES ☐ KIDNEY PROBLEMS ☐ OPEN WOUNDS ☐ CURRENT INFECTIONS
☐ HERNIA ☐ SEIZURES ☐ METAL IN BODY ☐ CANCER/TUMOR ☐ THYROID PROBLEMS ☐ CVA/STROKE ☐ ANXIETY
☐ PREVIOUS FRACTURES ☐ OSTEOPOROSIS ☐ DEPRESSION ☐ SUBSTANCE ABUSE ☐ HYPERSENSITIVITY TO HEAT/COL
☐ PRESENTLY PREGNANT ☐ HEPATITIS A ☐ HEPATITIS B ☐ HEPATITIS C ☐ OTHER

PLEASE DESCRIBE ALL OF THE ABOVE THAT YOU HAVE CHECKED:_____

_____

_____

_____

_____

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PATIENT HISTORY

PATIENT NAME: PATIENT AGE: DATE:

SURGICAL HISTORY

PLEASE LIST ALL THE SURGERIES YOU HAVE HAD IN THE PAST & SPECIFY WHICH SIDE:_____

_____

_____

_____

_____

_____

PHARMACY INFORMATION

PHARMACY NAME:_____

PHARMACY PHONE:_____

PHARMACY ADDRESS:_____

**REFILLS WILL ONLY BE DONE WHEN REQUESTED THROUGH THE PHARMACY OR WHEN YOU COME IN FOR AN APPOINTMENT. WE WILL NOT REFILL MEDICATION IF YOU CALL US AT THE OFFICE. ALSO PLEASE ALLOW THE PHARMACY AT LEAST 1-2 DAYS FOR A REFILL REQUEST SO PLEASE CALL IN YOUR REFILL REQUEST TO THE PHARMACY WHEN YOU HAVE ABOUT 1-2 DAYS WORTH OF MEDICATION LEFT OVER.

ALLERGIES TO MEDICATIONS(PLEASE LIST ALL MEDICATIONS THAT APPLY):_____

_____

_____

_____

SOCIAL HISTORY

DO YOU HAVE CHILDREN: ☐ YES ☐ NO IF SO HOW MANY?:_____ DO YOU LIVE ALONE?: ☐ YES ☐ NO

DO YOU SMOKE?: ☐ YES ☐ NO IF SO HOW LONG?:_____ HOW MANY PACKS PER DAY?:_____

IF YOU QUIT SMOKING HOW LONG AGO DID YOU QUIT?:_____

HOW LONG DID YOU SMOKE FOR?:_____ _____HOW MANY PACKS PER DAY?:_____

DO YOU DRINK ANY ALCOHOLIC BEVERAGES? IF SO WHAT KIND AND HOW OFTEN?:_____

_____

DO YOU HAVE ANY DRUG ABUSE OR ILLICIT SUBSTANCE ABUSE HISTORY?: ☐ YES ☐ NO IF SO, WHICH DRUGS AND HOW OFTEN?:_____

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MEDICATIONS

PATIENT NAME: PATIENT AGE: DATE:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING W/DOSES AND DIRECTIONS WHERE APPLICABLE

MEDICATION	DOSE	DIRECTIONS/COMMENTS