Arthritis & Osteoporosis Center
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Questionnaire for Bone Density Study

Name: _____
Address: _____
Phone Numbers: _____
Date of Birth: _____ Social Security: _____
Please list all doctors to whom you want a report sent:

Menopause Age (Females): _____ Ethnicity: _____ Sex: _____

For BMD Technician's use only: please continue to the next section:

Weight: _____ Current Height: _____Tallest Height: _____
Diagnosis Codes: _____

Please list medications that you take regularly that relate to bone health, including vitamins and calcium. Include how long you have been taking each medication:

Medication	*Length*	*Medication*	*Length*
1. _____		2. _____	
3. _____		4. _____	
5. _____		6. _____	

If you have had a Nuclear Medicine study, a CAT scan, or any other x-rays that require injections or swallowing barium within the last seven days, you will need to reschedule your appointment.

Bone Density Questionnaire

Are you presently taking calcium tablets? **Yes** **No**

If yes, what brand? _____ Strength? _____
How many per day? _____ How long have you been taking them? _____

Do you have any metal, such as staples, pins or shrapnel in your body? **Yes** **No**
If yes: What?_____ Where? _____

Have you had a hip replacement? **Yes** **No**
If yes: Which one? _____

Have you fractured or injured any of your vertebrae? **Yes** **No**
If you know which ones, please list:_____

Have you had any spinal fusions? **Yes** **No**
If yes: Which ones? _____

Please place a check mark next to any of the following statements that apply to you.

____ I am more than one inch shorter than I used to be.
____ I **am** a smoker. For how long? _____
____ I **was** a smoker. For how long? _____ When did you quit? _____
____ I have an overactive thyroid.
____ I have lactase deficiency (cannot digest lactose).
____ I have had an elevated blood calcium level.
____ I have a curvature of the spine.
____ I have had a family member with breast cancer. Who? _____
____ I have had a family member with osteoporosis. Who? _____
____ I drink more than 2 alcoholic drinks a day.
____ I drink caffeinated beverages.
____ I regularly consume dairy products.
____ I perform weight-bearing exercises regularly.

Have you ever taken any of the following medications?

Fosamax	Yes	No	How long?_____	Taking Now?	Yes No
Evista	Yes	No	How long?_____	Taking Now?	Yes No
Boniva	Yes	No	How long? _____	Taking Now?	Yes No
Forteo	Yes	No	How long? _____	Taking Now?	Yes No
Actonel	Yes	No	How long?_____	Taking Now?	Yes No
Estrogen	Yes	No	How long?_____	Taking Now?	Yes No
Calcium	Yes	No	How long? _____	Taking Now?	Yes No
Cortico Steroids	Yes	No	How long? _____	Taking Now?	Yes No
Miacalcin	Yes	No	How long? _____	Taking Now?	Yes No
Prednisone	Yes	No	How long? _____	Taking Now?	Yes No

Do you have any of the following medical conditions:

____ Hyperthyroidism
____ Hysterectomy
____ Cancer
____ Hyperparathyroidism
____ Asthma/Emphysema
____ Anorexia/Bulimia
____ Rheumatoid Arthritis
____ Any seizure disorders
____ Inflammatory Bowel Disease

What was your maximum height, in inches? _____
(Female) At what age did your period start? _____
(Female) How many children have you had? _____

To All Medicare Patients: Medicare will only pay for services that it determines to be "Reasonable and Necessary" under Section 1862 (A) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. Your doctor has requested a DEXA Bone Mass Measurement test to assist in your medical evaluation. Per the Medicare Newsletter dated October 13, 2000, No. 01-010, pages 6-10, Medicare may cover a Bone Mass Measurement for a beneficiary once every two years (if at least 23 months have passed since the month the last Bone Mass Measurement was performed). However, if medically necessary, Medicare may cover Bone Mass Measurements more frequently than every two years. Examples of situations where more frequent Bone Mass Measurements may be necessary include, but are not limited to, the following medical circumstances:

1.) Monitoring beneficiaries on long-term glucocortoid (steroid) therapy for more then three months;

2.) Allowing for a confirmatory baseline Bone Mass Measurement (either central or peripheral) to permit monitoring of beneficiaries in the future, if the initial test was performed with a technique that is different from the proposed monitoring method, e.g., if the initial test was performed using bone sonometry and monitoring is anticipated using bone densitometry, Medicare will allow coverage of baseline measurement using bone densitometry; and

3.) Allowing for the assessment of patient response to FDA-approved osteoporosis drug therapy. Your condition may require additional services and/or treatments than allowed by Medicare. We can apply for additional treatments by submitting a "medical necessity statement" on your behalf. Your case will be dent to review and we cannot guarantee or predict what the review board will decide in your case.

My Medical Doctor/Rheumatologist has notified me that not all services are covered by Medicare. If Medicare denies payment, **I agree to be personally and fully responsible for payment.**

_____

Patient's Signature **Date**

To All Patients: Some insurance companies do not cover Bone Mass Measurement Tests. Our office does not verify benefits. It is the responsibility of each patient to verify your coverage through your insurance company. Dr. Shams will be happy to submit this test to your insurance company; however, if they do not pay, the balance will become your full responsibility. To assist in making payment, your insurance company may require that Dr. Shams submit copies of your medical records.

By signing below I agree to be personally and fully responsible for payment if coverage is denied by my insurance company. I authorize direct payments for professional services, and I authorize the release of information for any purpose needed to collect payment on my account.

Please note: If your account remains delinquent for a period exceeding 120 days, your account will be turned over to an outside collection agency and you will be responsible for any and all applicable collection fees incurred.

There will be a $50.00 charge for any checks returned from the bank!

_____

Patient's Signature **Date**