Arthritis & Osteoporosis Center
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Questionnaire for Comparative Bone Density Study

Name: _____

Please list all doctors you want your report sent to: _____
_____

Please list all medications that you take regularly that relate to bone health:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you had a hip replacement? _____ If so, which one? _____
Have you had any fractures since your last bone density test? _____
If so, please list, along with date of fracture:

If there are any changes in your medical history you feel the doctor should know about, please list below:

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

Please leave this section blank

Weight: _____ Present Height: _____ Height at Last Study: _____
Diagnosis Codes: _____

Comparative Bone Density Questionnaire

1. Have you ever taken any of the following medications:

___Fosamax ___Actonel ___Cortico Steroids (Prednisone, etc.)
___Evista ___Estrogen ___Boniva
___Forteo injection ___Calcium ___Alendronate ___Vitamin D
___Reclast ___Prolia ___Boniva IV ___Miacalcin
Other - Please specify: _____

When and for how long were medication(s) taken? _____
Are you currently taking the medication(s)? _____

2. (Female) At what age did your period start? _____
3. (Female) How many children have you had? _____

4. What was your maximum height? _____

Please Circle Yes or No:

5. Do you have a family history of Osteoporosis?	**YES**	**NO**
6. Was it your parent?	**YES**	**NO**
7. Did your parent fracture a hip?	**YES**	**NO**
8. Do you perform weight-bearing exercises regularly?	**YES**	**NO**
9. Do you regularly consume dairy products?	**YES**	**NO**
10. (Female) Ever missed your period more than 6 months at a time (not including pregnancy/menopause)?	**YES**	**NO**
11. Any fracture(s) during your adult life which did <u>not</u> result from significant trauma (i.e. auto accident, fall)?	**YES**	**NO**
12. Do you smoke?	**YES**	**NO**
13. Have you **<u>ever</u>** smoked? If so, when & for how long? _____	**YES**	**NO**
14. Do you drink 3 or more alcoholic beverages a day?	**YES**	**NO**
15. Do you drink caffeinated beverages (coffee, soda, tea)?	**YES**	**NO**

16. Do you have any of the following medical conditions? (Please circle)

Hyperthyroidism Hyperparathyroidism Rheumatoid Arthritis
Hysterectomy Asthma or Emphysema Any Seizure Disorders
Cancer Anorexia or Bulimia Inflammatory Bowel Disease
Other - Please specify: _____

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 sent to review, but 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 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 including court costs.

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

Patient Signature _____ **Date** _____