NEW MEXICO
Clinical Research &
Osteoporosis Center, Inc.

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Other Insurance (Non-Medicare)

Beneficiary Liability Waiver of Non-Covered Service

Patient Name: _____

Insurance Co: _____

There is a chance that your insurance company will not pay for the following service(s) described below. Your doctor or other health care provider may recommend you get services more often than your insurance plan does not cover. If this happens, you may have to pay some or all of the costs.

Services to be Received	Reason Insurance May Not Pay:	Estimated Cost:
☐ Bone Density Test (DXA) ☐ Vertebral Fracture Assessment (VFA)	☐ Service never paid due to medically unnecessary. ☐ Your diagnosis does not support the need for this service. ☐ Frequency Limitations for coverage	☐ **$165+ tax**

Although we may not be required by your insurance plan to provide you with this notice, the purpose of this form is to help you make an informed choice about whether you want to receive these service(s) knowing that you may be responsible for the cost.

☐ Yes, I want to receive these service(s), and I want to have my insurance billed.
☐ Yes, I want to receive these service(s), and I **do not** want my insurance billed. I will pay now.
☐ No, I do not want to receive these service(s).

Most insurance companies may pay for screenings once every 24 months (UnitedHealth Care once every 36 months) and follow national guidelines for determining if the test will be covered. You are responsible for checking the coverage requirements of your insurance plan.

I understand that by signing this form, I will be fully responsible for the above estimated cost if I have elected to receive this service(s). I also understand that it is my choice to have these service(s) provided by New Mexico Clinical Research and Osteoporosis Center.

_____ _____

Signature **Date**

Bone Densitometry: Patient History Form

Revised 12/17

NEW MEXICO CLINICAL RESEARCH &OSTEOPOROSIS CENTER, INC.

Name:	DOB:	Date:
Address:	Home Phone:	Cell Phone:

Osteoporosis Risk Factor Assessment

	Yes	No
Are you a postmenopausal woman?	❒	❒
Have you lost more than 2 in. height?	❒	❒
Have you broken bones since age 40?	❒	❒
Does your mother or father have osteoporosis? ❒Mother ❒Father	❒	❒
Has your mother or father had a broken hip? ❒Mother ❒Father At what age?_____	❒	❒
Do you smoke cigarettes?	❒	❒
Have you ever taken steroids, such as prednisone, for more than 3 months?	❒	❒
Are you now taking prednisone?	❒	❒
Have you been on chemotherapy?	❒	❒
Do you have kidney disease? Nephrologist _____	❒	❒
Do you have rheumatoid arthritis? Rheumatologist_____	❒	❒
Do you take anticonvulsant medication, like Dilantin, phenobarb, or Tegretol?	❒	❒

	Yes	No
Do you have any thyroid problems? ❒hyper (overactive) ❒hypo (underactive) Endocrinologist_____	❒	❒
Do you have any parathyroid problems? ❒hyper (overactive) ❒hypo (underactive) Endocrinologist_____	❒	❒
Do you have a high calcium level in your blood?	❒	❒
Do you have inflammatory bowel disease, Crohn's disease, or ulcerative colitis?	❒	❒
Do you have malabsorption problems or celiac disease?	❒	❒
Have you had stomach surgery, such as gastrectomy or stapling?	❒	❒
Have you had anorexia?	❒	❒
Have you had bulimia?	❒	❒
Have you had an organ transplant?	❒	❒
Do you have a paralyzed arm or leg?	❒	❒
Do you have 3 or more alcohol drinks per day?	❒	❒

Do you currently take or have you ever taken the following medications?

		Dose	Date Started	Date Stopped	Reason Stopped
❒	Calcium			❒current	
❒	Calcium with Vitamin D			❒current	
❒	Multivitamin			❒current	
❒	Vitamin D			❒current	
❒	Estrogen ❒patch ❒pill ❒cream			❒current	
❒	Testosterone			❒current	
❒	Prednisone			❒current	
❒	Fosamax (alendronate)			❒current	
❒	Actonel, Atelvia (risedronate)			❒current	
❒	Evista (raloxifene)			❒current	
❒	Miacalcin, Fortical (calcitonin)			❒current	
❒	Forteo (teriparatide)			❒current	
❒	Boniva (ibandronate)			❒current	
❒	Reclast (zoledronic acid)			❒current	
❒	Prolia (denosumab)			❒current	
❒	Abaloparatide (tymlos)			❒current	
❒	Didronel (etidronate)			❒current	
❒	Strontium			❒current	

Please list all other medications you are currently taking. (Write none if none)

Bone Densitometry: Patient History Form

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NEW MEXICO CLINICAL RESEARCH &OSTEOPOROSIS CENTER, INC.

Name:	Date of Birth:	Today's date:

Have you ever broken or fractured a bone? ❒ Yes ❒ No

Which bone?	Age	What happened?
❒right ❒left		
❒right ❒left		
❒right ❒left		
❒right ❒left		

Do you exercise regularly? ❒ Yes ❒ No

Form of exercise	Frequency per week	Length of time per workout

What was your <u>height</u> at age 25? _____ <u>Weight</u> at age 25?_____

Gender Specific Risk Factors

<u>For women only:</u>

At what age was your **<u>LAST</u>** period? _____
How did menopause begin?
❒Natural ❒Hysterectomy
If you have ever had a hysterectomy, which describes your procedure?
❒Both ovaries were removed
❒One ovary still remains
❒Both ovaries still remain
Are you currently having irregular periods?
❒Yes ❒No
Has there been an episode when your period stopped for a significant amount of time?
❒Yes ❒No
Have you ever had phlebitis or blood clots?
❒Yes ❒No
Have you had breast cancer?
❒Yes ❒No
If yes- Date diagnosed _____
❒right ❒left
❒chemo ❒radiation ❒surgery
Have you ever taken or do you currently take Femara (letrozole), Arimidex (anastrazole), Aromasin (exemestane), or Tamoxifen?
❒Yes ❒No If yes, for how long? _____
Have you had cancer of the…
❒Ovary (❒right or ❒left) ❒Uterus ❒Cervix ❒None
If yes- Date diagnosed _____
❒chemo ❒radiation ❒surgery

<u>For men only:</u>

Do you have erectile dysfunction (impotence)?
❒Yes ❒No
Do you have low testosterone?
❒Yes ❒No
Have you had prostate cancer?
❒Yes ❒No
If yes- Date diagnosed _____
❒chemo ❒radiation ❒surgery
Are you currently receiving hormonal treatments for prostate cancer?
❒Yes ❒No

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Name:	**Date of Birth:**	**Today's date:**

Who ordered this bone density test? _____

Shall we fax copies of your report to any other physician? _____

What is the reason for doing this bone density test? _____

Have you had a bone density test before? ❒No ❒Yes When and where? _____

Ethnic Group: ❒Caucasian ❒Hispanic ❒Asian/Pacific Islander ❒African-American ❒Other: _____

Sex _____

May we contact you for possible participation in research studies? ❒Yes ❒No

Are there any details to any of your answers on this questionnaire you feel we should know?

_____

_____

_____

_____

For Official Use

HT					cc:		
WT	L	R	JC	MG	BW	DXA	

Notes