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928 Travis Ave, #104

Ft. Worth, TX 76104

P: (682) 286-1309 F: (682) 707-2989

Today's Date: _______________

Patient Name: ____Date of Birth:_________________________

SSN: ____Gender: M / F

Marital Status: _______________________________________ Ethnicity: ____________________________

Address: ____

Main Phone #:____Alt. Phone#:___________________________

E-Mail Address: ____

Primary Care Physician: ______________________________Referred By: __________________________

Employer: ____ Preferred Language:__________________

Currently in Facility: Y /N Name of Facility: ____

Emergency Contact Information

Name: ____ Phone: ______________________________

Address: ____

Preferred Pharmacy

Pharmacy Name: _______________________________________Phone#:____________________________

Primary Insurance:

Name: ____ Phone#:________________________

Insured Name: _____________________________________Relationship to Patient:____________

Insured Date of Birth: ________________________Insured Social Security: __________________

Employer / Group Name: ____

ID #:____ Group #:___________________________

Secondary Insurance

Name: ___________________________________Insured Name: ___________________________

ID #:____

I authorize The Center for Osteoporosis & Bone Health to bill the above insurance. I understand that this order does not relieve me of my obligation to pay for such bills if not paid by insurance, or any balance due after payments by my insurance company. I, hereby, consent to treatment by The Center for Osteoporosis & Bone Health.

Patient
Signature:______________________________________Date:__________________________

Allergies:

____
____

Please list all Supplements or Vitamins you are currently taking:

____
____

Please list all medications you are currently taking (or provide a list):

____
____
____

Please list all medical problems / surgeries:

____
____

Height: ________________ Weight: ________________ History of Fracture: Y / N

Did either parent previously have a fractured hip? Y / N

Currently smoke tobacco? Y / N Have you had long term steroid use? Y / N

Have you had confirmed diagnosis of Autoimmune Disease? Y / N
(This includes Rheumatoid arthritis, Lupus, Psoriatic Arthritis)

Medications:

Medication	How long have you been taking?	Last Dose
Fosamax (Alendronate)		
Didronel (Etidronate)		
Boniva (Ibandranate)		
Aredia (Pamidronate)		
Actonel (Risedronate)		
Reclast (Zoledronate)		
Fortical (Calcitonin)		
Miacalcin (Nasal Spray)		
Estrogen/ Hormone Therapy		
Evista (Raloxifene)		
Forteo (Teriparatide)		
Prolia (Denosumab)		
Anticonvulsants (Gabapentin, Lyrica,Lamictal, ETC)		
Anticoagulants (Heparin, Coumadin)		
Opioids (Oxycodone, Hydrocodone, Oxycontin, ETC)		
Oral Steroids (Prednisone)		
PPIs (Nexium, Prilosec, ETC)		
SSRIs (Lexapro, Celexa, Sertraline)		

The Center for OSTEOPOROSIS & Bone Health

Name (print): ____ Date: _________________

Is there a chance that you are pregnant? Yes No

Have you had a barium X-ray in the last 2 weeks? Yes No

Have you had a nuclear medicine scan or injection of an X-ray dye in the last week? Yes No

Have you had hyperparathyroidism or a high calcium level in your blood? Yes No

If you answered yes to any of the above, we will need to schedule your test at another visit.

1. Your: Age: ____
2. Your country of birth: _______________________
3. Have you ever had a bone density test? Yes No

   If YES, when and where? ____
4. Have you had a recent weight change? Yes No

   If YES, tell us about it: ____
5. Your tallest height (late teens or young adult): _______________
6. Have you ever broken a bone? Yes No

Bone broken	Simple fall?	If not a simple fall, please describe the circumstances	Age when this occurred

7. Has a parent or sibling had a broken hip from a simple fall or bump? Yes No

8. Has a parent or sibling had any other type of broken bone from a simple fall or bump? Yes No

9. How many times have you fallen in the last year? ________

10. Have you ever had surgery of the spine, hips, legs or arms? Yes No

    If YES, describe what type of surgery you had and which side was affected

    ____

    ____

11. Are you currently receiving or have you previously received prednisone pills (cortisone)?

    Yes, currently ____ Yes, previously _____ No ____

    If YES, for how long? ________ What is your dose? _____mg or ______ pills each day

12. Do you take any calcium supplements (including TUMS)? Yes No

13. Do you take any vitamin D supplements (including multivitamins and halibut liver oil)? Yes No

14. Do you smoke? Yes No

For women only…

15. Are you still having menstrual periods? Yes No

16. Before menopause, have you ever missed your periods for 6 months or more, besides during pregnancy? Yes No

17. Have you had your menopause? Yes No

    If yes, at what age? ___________

18. Have you had a hysterectomy? Yes No

    If YES, at what age? _______

    Have you had both of your ovaries removed? Yes No

    If YES, at what age? ________

Patient Waiver for Non-Covered Services

Your insurance does not pay for all of your health care costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your physician believes that the services below although they may not be covered by your health insurance, are an important part of your current treatment plan. Should you choose to receive these services; you will be personally responsible for the payment of such services.

The services recommended by your physician are listed below:

- Vitamin D
- Calcium
- PTH- (**Parathyroid Hormone)**
- P1NP- (Procollagen Type I Intact N-Terminal Propeptide)
- CTX- (**C Telopeptide)**
- Other: ____

The total cost for the services is depending on your personal lab benefits. I acknowledge that I have been informed in advance of receiving these services, that these services may not be covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges.

Patient Name: ____

Patient Signature: ____

Date: _____________________________

MEDICAL RECORDS RELEASE AUTHORIZATION

DATE: _________________ RE: ____

TO: ____

PHONE: _______________________________________

FAX: ____

I hereby authorize and request you to release records to:

THE CENTER FOR OSTEOPOROSIS & BONE HEALTH

928 TRAVIS AVE, #104

FORT WORTH, TX 76104

PHONE: 682-286-1309

FAX: 682-707-2989

The complete medical records in your possession, concerning my health and / or treatment.

We are requesting: ____.

Patient Signature: ____

Date: ______________________