

COMPLETE THIS SECTION ONLY IF HAVE OTHER INSURANCE

Other Insurance Co. Name _____

Group# _____ ID# _____

Insurance Coverage: Primary Secondary

Patient relationship to Insured: Self Spouse Child

If relationship to insured Other than Self, Please complete below:

Policy Holder
(Insured)

Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Employer _____

Other Insurance Co. Name _____

Group# _____ ID# _____

Insurance Coverage: Primary Secondary

Patient relationship to insured: Self Spouse Child

If relationship to insured Other than Self, Please complete below:

Policy Holder
(Insured)

Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Employer _____

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MEDICAID ID # (Exactly as it appears on the card) _____

MEDICAID patients please show your monthly eligibility slip to receptionist.

Patient relationship to insured: Self Spouse Child

Policy Holder
(Insured)

Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM (Please sign your name below). I hereby authorize photocopies of this form to be as valid as the original. I understand I can withdraw this authorization at any time, by notifying this office in writing. I hereby authorize treatment of the above patient and agree to pay all fees and charges for treatment regardless of insurance coverage or the pendency of insurance claims.

Date _____

X

Patient's or authorized person's signature



ARTHRITIS CENTER OF NEBRASKA

Melvin A. Churchill MD Alan J. Jacobs MD Rick C. Chatwell MD Robert M. Valente MD

Board Certified Rheumatologists Providing Comprehensive Rheumatologic Care and Osteoporosis Evaluation

Date _____

PLEASE NOTE

We are requesting the following information in order to better serve you and to ensure the proper routing of medical reports. Please complete the following using black or blue ink:

*It is very important the doctor's first and last name be listed along with the city and state.

Patient Full Name (please print): _____

City, State (please print): _____, _____

Family Physician: _____ (First Name) _____ (Last Name) _____ (MD, PA, NP)

City, State: _____, _____

*If PA (Physician Assistant) - which Doctor does he/she practice under?

Pharmacy Preferences:

Pharmacy 1 _____
(Name) (Address-Example: 56th & Highway 2) (Phone #)

Pharmacy 2 _____
(Name) (Address) (Phone #)

Pharmacy 3 _____
(Name) (Address) (Phone #)

Thank you for taking the time to provide this information to our office.

Please do not write in shaded areas

BONE DENSITY QUESTIONNAIRE

Arthritis Center of Nebraska

Yes ___ Postmenopausal; Yes ___ HRT; ___ Compression Fx; ___ Kyphosis; ___ Osteopenia/x-ray
No ___ No ___ Wt _____
Ht _____
Previous/young Ht _____

Please complete front and back: Please bring ALL medications with you including supplements

Date of Scan: _____ Date of Previous Scan if any: _____
Name: _____ Birthdate: _____
(First) (M.I.) (Last)
Address: _____ City: _____ State: _____ Zip: _____
Referring Physician: _____ Primary Physician: _____
Reason for scan: _____

Age: ___ Gender: F ___ M ___ Race: White ___ Asian ___ Black ___ Hispanic ___
Family history of osteoporosis? ___ If yes, what kind of fractures occurred? _____
Have you had any prior osteoporotic fractures? ___ No ___ Yes If yes, where? _____
Have you ever smoked cigarettes? ___ No ___ Yes How many years? _____
Do you drink 2 or more alcohol beverages a day? ___ No ___ Yes

Check if you have had the following:

_____ Cancer of the breast	_____ Thyroid replacement	_____ Sprue
_____ Cancer of the uterus	_____ Rheumatoid arthritis	_____ Anorexia nervosa
_____ Cancer (other)	_____ Kidney failure	_____ Illness leading to months of bedrest
_____ Crohn's disease	_____ Organ transplant	_____ Kidney stones
_____ Ulcerative colitis	_____ Dialysis (chronic)	

Check if you have had the following surgeries:

_____ Spinal fusion	_____ Other lower back surgery
_____ Hip replacement	_____ Partial stomach removal
_____ Small intestine surgery	

Check if you have taken the following:

_____ Lasix (Furosemide)	_____ Inhalers
_____ Cyclosporin	_____ Prednisone (more than 2 months)
_____ Dilantin	_____ Thyroid replacement

Do you walk or exercise for 20 minutes at least 4 times a week? ___ No ___ Yes

Do you feel unsteady when standing or walking? ___ No ___ Yes

DIET

_____ mg

Estimate the number of servings you eat each day:

Group A 300 mg Milk (8 oz) _____ Yogurt _____ Calcium enriched juice _____

Group B 150 mg Cheese _____

Group C 75 mg Cottage Cheese _____ Ice Cream/Ice Milk _____ Pudding with milk _____

Medication

Calcium _____ mg

VIT D _____ IU

List the names of your current medications including calcium and vitamin supplements:

For prednisone users of 2 months or more (past or present):

Started at age _____ Estimated average dose _____ Years of use _____

If on Boniva, estimate when it was started _____ month _____ year Stopped _____ month _____ year

If on Fosamax, estimate when it was started _____ month _____ year Stopped _____ month _____ year

If on Miacalcin, estimate when it was started _____ month _____ year Stopped _____ month _____ year

If on Actonel, estimate when it was started _____ month _____ year Stopped _____ month _____ year

If on Forteo, estimate when it was started _____ month _____ year Stopped _____ month _____ year

If on Evista, estimate when it was started _____ month _____ year Stopped _____ month _____ year

For women only

If menopausal, at what age? _____ years (include surgical removal of ovaries)

If not menopausal, are your periods regularly? _____ No _____ Yes

For postmenopausal women, check the appropriate area:

_____ No, never took estrogen

_____ Yes, have taken or am currently taking estrogen

If yes, names _____ Dosage _____

Date started _____ Still taking _____ If stopped, when _____