N.C.I.B.H. REGISTRATION FORM

Date ______________

Section I—About You

Name ____
Last First Middle

Address ____
Street City State Zip

Home phone: (____) ___________ Social Security Number: ________________

Email address:________________________________ Fax:________________

Date of birth: ____/____/____ Male___ Female___Referred by__________________

Name of Employer: ________________ Employer Phone Number: ________________

Employer Address: ____
Street City State Zip

[1] Name of physician to receive report: ________________________________

Address: ____
Street City State Zip

[2] Additional physician to receive report: ________________________________

Address: ____
Street City State Zip

[3] Additional physician to receive report: ________________________________

Address: ____
Street City State Zip

May we contact you about participating in clinical research studies? ______*Yes* ______ *No*
Initials **initials**

Section II—About Your Insurance

[1] Name of Primary Insurance Company:

☐ Medicare ☐ Other: ________________________________

[1a] Name of Subscriber:

☐ Self ☐ Other: ______________________________ DOB:___/___/_____

Other Subscriber SS#:__________________________________

[2] Name of Secondary Insurance Company:

____

[2a] Name of Subscriber:

☐ Self ☐ Other: ___________________________ DOB:____/____/______

Other Subscriber SS#:____________________________________

Section III- Records Release

By signing below, you acknowledge that the results of your bone density test can or may be sent via facsimile to your physician and, if applicable, to the other medical providers that you have indicated on the reverse side of this form. **Moreover, your signature below allows for the fax and/or release of any of your previous bone density reports and pictures from any facility other than NCIBH.**

Section IV- Financial Responsibility

Medicare: NCIBH accepts assignment from Medicare. If I do not have a secondary insurer (a Medicare supplement), I understand that I will be responsible for the co-payment.

Other insurance: I understand that, for insurance to cover this test, I need (1) a prescription from my physician, and (2) authorization from my insurance company to have the test performed at NCIBH, if required. I am responsible for getting the prescription and making sure that either I or my physician gets any prior authorizations(s) which is/are required.

Patient liability: I am responsible for payment if my insurance does not pay for this test.

____________________________________ ____________________

Patient's Signature **Date**

____

Print Name

NORTHERN CALIFORNIA INSTITUTE FOR BONE HEALTH, INC.
3100 Telegraph Avenue
Suite 3000
Oakland CA 94609-3223
Phone: (510) 625-9100 Fax: (510) 625-9123

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem costing patients inconvenience, aggravation, and money. We want you to know that all of our employees, technicians, and physicians continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. It has always been our policy not to release any medical information or records to anyone that has not been authorized by you the patient. We are continuing that policy in compliance with recent regulations affecting PHI.

Thank you for being one of our highly valued patients!

____

Patient Signature

Northern California Institute for Bone Health, Inc.
3100 Telegraph Avenue
Suite 3000
Oakland CA 94609-3223
Phone: (510) 625-9100 Fax: (510) 625-9123

PATIENT QUESTIONNAIRE

Name_______________________________

DOB________________________________

Sex______Weight________Height_________

Ethnicity_____________________________

MD who ordered test____________________

Primary Care MD______________________

Other consulting MD's___________________

Is there a chance you might be **PREGNANT**? no/yes

Medications taken (prescription & over the counter):

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Have you had previous central (hip/spine) bone density tests, DXAs (DEXAs) no/yes

Peripheral bone density tests (forearm, heel, ultrasound) no/yes

Where ___________________________

When ____________________________

Have you had a nuclear medicine study or a study with **contrast** (Upper GI, CT, barium enema) less than 10 days ago?   no/yes

If so, please call/tell our receptionist to reschedule your appointment as contrast will affect your test results.

Have you had any fractures (broken bones)   no/yes

If yes, body part/site____________________

How old (age or year) were you?_________________

How did they occur (e.g. fall, auto accident, etc.)___________________________

Have either of your parents had any fractures?   no/yes

Mother	Father
Hip n/y	Hip n/y
Body part/site__________	Body part/site_________
How old? ____________	How old? ____________

Any of your siblings (brothers or sisters) had any fractures? no/yes

Siblings
Hip n/y
Body part/site_________
How old?____________

Do you currently smoke tobacco? No/yes
how much?____________

How old when started?______________

Did you previously smoke tobacco? no/yes How much?__________

How old when started?_________How old when stopped?________

Did you ever take corticosteroids (steroids, prednisone, prednisolone etc, pills, iv)? no/yes

Why?________________How much?____________How many years?________ More than 3 months? no/yes

Do you have rheumatoid arthritis? no/yes

If yes, how many years? ______________
Treatment?_____________________________

Have you been told you have any other medical condition that might have weakened your bones? no/yes

If yes, what condition?____

Celiac Disease no/yes

Organ transplant no/yes

Pagets disease no/yes

Immobility no/yes

Kidney dialysis no/yes

Kidney failure no/yes

Other?____

Do you drink alcohol? no/yes

Do you take more than 2 units (a unit is a can of beer, glass of wine, shot of hard alcohol) daily? no/yes

Are you taking any treatment for osteoporosis now? no/yes

Calcium: What type & strength________________How many/day__________

Vitamin D: What type & strength_______________How many/day__________

Estrogen (please circle) patch pill cream strength_______How long?______

Progesterone (please circle) patch pill cream strength_______How long?______

Raloxifene (Evista™)

Bisphosphonates:

Oral:
Alendronate (Fosamax™) pill liquid
5mg/d 10mg/d
35mg/wk 70mg/wk
70mg Plus D

Ibandronate (Boniva™)
150mg monthly
Other

Risedronate (Actonel™) 5mg/d 35mg/wk

IV Pamidronate (Aredia™) How much? How often? How long?

Zoledronic Acid (Zometa™ or Reclast™) How much? How often? How long?

Testosterone patch/pill/shot How much?______How often?_______How long?______

Other__________________ (etidronate(Didronel™), tibolone, strontium, etc.)

Anabolic Agent:

Teriparatide (Forteo™) How often?________How long?________When started?________When finished?______________

Type I Diabetes Mellitus? no/yes

Type II Diabetes Mellitus? no/yes

High blood calcium no/yes

Sun exposure? no/yes

Don't go out in sun much ___________ not at all______________

Sun block use? no/yes Usual SPF used?_____Before going into the sun? no/yes

After going into the sun? no/yes

Hyperthyroidism? no/yes

Hypothyroidism? no/yes

Thyroid medication? no/yes If yes, what type?_________________

Dosage:_____________

Dairy product intake:

What:____

How often:____

Lactose intolerant: no/yes

Have you ever had radiation therapy for cancer? no/yes

Have you ever had a blood clot? no/yes If yes, When?_______________ Where in body___________________

Have you ever had breast cancer? no/yes

Have you ever had ischemic heart disease (heart attack, angina, coronary artery disease)? no/yes

Eating disorder (bulimia, anorexia)? no/yes If yes, for how long?____________ lowest weight_______________

Gastric Bypass? no/yes If yes, how old were you?_____Type if you know?__________

Have you fallen in the last year? no/yes

Have you fallen in the last month? no/yes

Hip, spine or forearm surgery? no/yes if spine, what type ______ what level______

Joint replacements? no/yes

Scoliosis? no/yes

Ever been told you have curvature of the spine or arthritis in the spine? no/yes

Exercise?___________________What kind?_______________________

How many times per week? ___________How long each session?_______________

Men only:

Have you experienced impotence or decreased sexual function? no/yes

Women only:

Menarche (periods started) at what age?_____________

Regular? no/yes Irregular? no/yes

Menopause (periods stopped) at what age?___________

Did periods stop naturally? no/yes

Periods stopped through chemotherapy? no/yes

Hysterectomy? no/yes Ovaries removed? one/both

Periods stopped through other means?________________________

Amenorrhea (periods stopped for six months or more not due to pregnancy)? no/yes

Number of pregnancies____________ Age of first pregnancy _______________

Have you ever used DepoProvera? no/yes If yes, for how long?_________

Have you ever used oral contraceptives no/yes if yes, number of years_______

If yes, type/name remembered

____

Would you be interested in participating in research studies? yes/no