Metabolic Wellness

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230 South Nevada Montrose, CO 81401 (970) 787-9647

BONE DENSITY /DXA EXAM

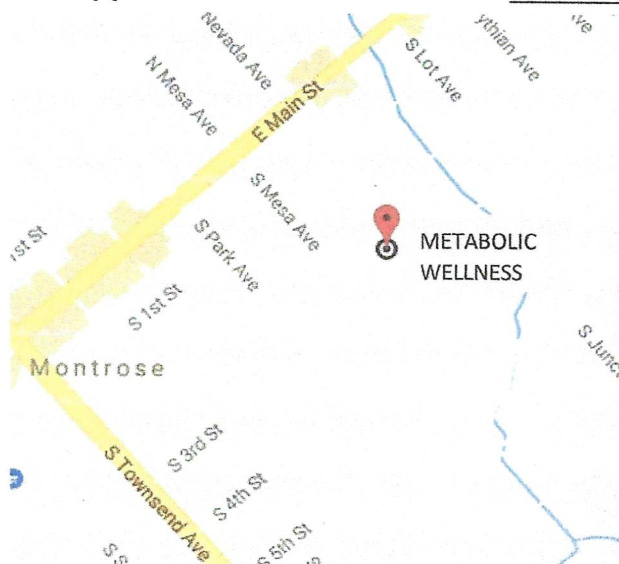
DXA is a fast, convenient, precise, and painless way to measure bone density to determine a patient's risk of developing osteoporosis. The sites to be examined are the fracture-prone hip, spine, and sometimes the forearm. Bone Mineral Density (BMD) is calculated and compared to normal BMD Values. It is then matched for age to confirm or exclude osteoporosis. A low BMD by DXA may predict the likelihood of having a fracture and can help determine a treatment plan. A report will be sent to your doctor that consists of your bone density measurements, a comparison of your results against a database of other patients your age, and will have recommendation for treatment or prevention.

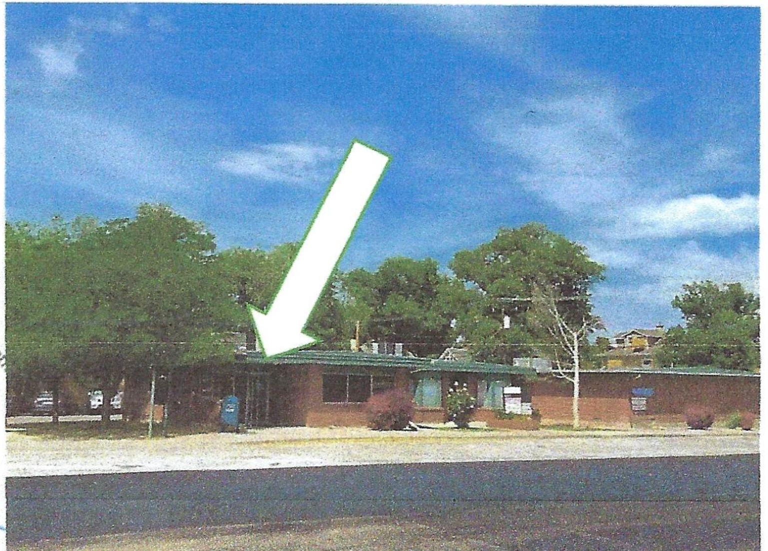
Before your appointment:

- If you have had a DXA in less than 2 years, your insurance may not cover this test unless there is a specific reason that your provider has requested it.
- Eat normally on the day of the exam.
- If you take calcium supplements, **DO NOT** take calcium supplements within 24 hours of appointment.
- Please **DO NOT** wear any clothing with metal such as buckles, zippers, snaps, etc. Sports bras are recommended. If you are unable to wear clothing free of metal we will provide a medical gown that you may change into.
- If you have had a barium study, radioisotope injection, or oral/intravenous contrast material from a CT scan or MRI within 7 DAYS prior to this DXA exam you MUST reschedule your appointment for a later date.
- If you have had a **previous bone density scan** done at another facility, **please bring a copy** for comparison if possible.
- Bring all current insurance cards and this packet.

Please arrive at **Metabolic Wellness 230 S Nevada** 10 minutes prior to your appointment. If you have any questions or concerns, please call us at **(970) 787-9647.**

Appointment time and date :____





DXA PATIENT REGISTRATION

Section 1 – patient information

Last Name:_______________First Name:__________________MI:_____

Billing Address:______________________________________Apt#_____

City_____________________________________State_____Zip________

Home Phone (   )_________________Work Phone(   )____________

Employer Name: ____

Date of Birth:________________Social Security# __________________

Relationship to Policy Holder/Guarantor: _________________________

Referring Physician____

Section II-Release of Information and Financial Responsibility

1. I authorize the release of medical information necessary to process my insurance claim.
2. I understand that I am financially responsible for all charges incurred including any co-payments or co-insurance that may be required per agreement with my insurance company or payment in full at time of service.
3. I certify that all of the above information is true and correct to the best of my knowledge.

____

Signature Required   Date

OSTEOPOROSIS QUESTIONNAIRE

Important to answer ALL Questions.

Name: ______________________ Sex: ___ Birth Date: ___/___/___ Age_____

Present Height: _____ Present Weight: ______ (recent doctor office visit Height/Weight)

(Must answer) Race: __________ Referring Physician: ________________

HAVE YOU HAD A BARIUM X-RAY OR NUCLEAR MEDICINE TEST WITHIN THE LAST 2 WEEKS? YES NO (CIRCLE ONE)

Have you had a bone density test in the past? YES NO

When and where was it done? ____________________________ Year?________

(Women ONLY) fill in ALL blanks

IS THERE ANY CHANCE YOU MAY BE PREGNANT? YES NO

Have you : Had a hysterectomy? YES NO AGE:__________

Had your ovaries removed? YES NO AGE:__________

Gone through menopause? YES NO AGE:__________

Has it been five years since your last menstrual cycle? YES NO

Are you currently taking estrogen? YES NO

Name of medication?______________ How long? ________ What dose? _________

If you are not currently taking estrogen, have you taken it in the past? YES NO

How long did you take it? ____________ When did you discontinue it? _________

Name of medication? _________________________

Are you currently taking testosterone? YES NO

Which form of testosterone are you taking?________________ How long?__________

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1. DO you take any prescription medication for Osteoporosis? YES NO

   Medication (Fosamax, Miacalcin, Actonel, Evista, Zometa, Forteo, Boniva, Reclast, Prolia)

   What dose?______ How long? _________.

2. Do you take vitamins? YES NO How long? ________

3. Do you take calcium? YES NO How long? ________

4. Do you regularly take thyroid hormones? YES NO

   Which medication or you taking? Synthroid / Levothyroxine

   Date of last blood test? ___________

5. Do you regularly take corticosteroids (Prednisone)? YES NO

   If yes, What dose? _______ How long? ________ For what condition? ___________

6. Do you take Dilantin, Neurontin, or other medication for seizures? YES NO

   What dose?_______________ How long? ___________

7. Have you ever been diagnosed with Celiac Disease? ___________________

8. Do you take inhaled steroid for Asthma? YES NO

   If so what medication and what dose?________________________

9. On a weekly basis, do you consume more than 7 alcoholic beverages? YES NO

10. Do you have Rheumatoid Arthritis? YES NO Prednisone use? YES NO

11. Do you currently smoke cigarettes? YES NO

    How long? ___________ Packs per day? ______

12. Did you smoke in the past? YES NO

    How long? ________________ Packs per day? _________

    When did you quit? ____

13. During the average week, do you do any of the following for 20 minutes or more, three times a week? YES NO

    Activity: swim, bike, walk, dance, aerobics, racket sport, etc,___________________.

14. Did your mother, sister, aunt or grandmother ever break a hip, wrist, or rib after the age of 45 and/or have the diagnosis of osteoporosis? YES NO

    Explain:___________________________________

15. Since the age of 45, have you broken any bones? YES NO

    What, When? ______________________________How?______________________.

16. Have you experienced a height loss of at least 1.5 inches in your lifetime? YES NO

    If yes, how much height? ______________________________________

17. Have you ever been diagnoses with a significant curved upper back? YES NO

Have you been told you have: Kyphosis Lordosis or Scoliosis

18. Have you ever had any type of spinal surgery? YES NO

When and why? ______________________________.

20. Have you ever had a hip replacement? YES NO

Due to a fracture or arthritis? ____________ Was it the Right or Left hip? ________

21. Have you fallen in the last 6 months? YES NO How many times? _______

22. Are you steady on your feet? YES NO

If not, what do you use for assistance? ______________________.

23. Do you have: Any problems with incontinence or leaky urine? YES NO

Trouble reaching the bathroom on time? YES NO

Problems with leaky urine when coughing/sneezing? YES NO

24. Have you ever been diagnosed with any type of cancer (breast, prostate, etc.)?

YES NO Medications?______________________________________

25. Have you ever suffered from an eating disorder? YES NO Anorexia or Bulimia

26. Are you right or left handed? RIGHT LEFT

(Men ONLY)

Do you have any problems with erectile dysfunction? YES NO

Hypogonadism or low Testosterone? _____________________

IMPORTANT NOTICE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Dr. Gayle Frazzetta, M.D.

Effective April 14, 2003, revised federal regulations restrict the use and disclosure of your private health information (PHI) by our practice and other organizations. It has been, and continues to be, the policy of our practice to protect the privacy of our patient's health information and to comply with any regulations regarding the use of disclosure of patient health information. The following summarizes the new law and under what circumstances it may be disclosed.

Permitted Disclosures

Our practice is permitted to use and disclose your PHI for treatment, payment and health care operations purposes. These uses include sharing your PHI with other health care providers for confirmation of a diagnosis, using your PHI to accurately bill services we provide to you, providing your PHI to your insurance company for reimbursement, to remind you of appointments and as part of our quality improvement program.

We are permitted to disclose your PHI in compliance with guidelines outlined by law and when required to do so by various government agencies. We may also disclose your PHI to family members, relatives or close personal friends when the information is relevant to individual's involvement with your care or instructions for care. We will disclose your PHI when we refer you to other physicians or health providers. We reserve the right to change a privacy practice described in this notice as may be permitted or required by law and to make such change effective for all protected health information.

Restricted Disclosures

You have the right to request restrictions on certain uses and disclosures of your PHI along with the right to request portions of your PHI be amended. Our practice is not obligated to agree to request restrictions or to amend your PHI in the manner you request. You have the right to inspect and receive a copy of your PHI with a reasonable charge for the labor and costs associated with copying your PHI. You have the right to receive an accounting of disclosures of your health information.

Authorization for other uses

Our practice will make other uses and disclosure of your protected health information ONLY after obtaining your written authorization. If you authorize a use not contained in this notice, you many revoke your authorization at any time by notifying us in writing that you request to revoke your authorization.

Concerns

If you believe your privacy rights have been violated, you may make a complaint by contacting Dr. Gayle Frazzetta, 224 S. Nevada Ave. Montrose CO 81401, 970-252-9644 or the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filing a complaint.

Acknowledgment

I acknowledge that I have signed and received a copy of the Notice of Privacy Practices regarding the use and disclosure of my private health information.

____ ____________________

Patient Signature Date