



**Bone Density Worksheet**

Name: ..... Date of Birth: .....

Gender:  M  F Ethnicity:  White  Black  Hispanic  Asian

Height: ..... Weight: ..... Age at Menopause: .....

Referring Physician Name: .....

- Have you ever had a bone density study at this office?  Yes  No
- Did you ever fracture or have surgery on your wrist?  Yes  No
- Did you ever fracture or have surgery on your hip?  Yes  No
- Did you ever fracture or have surgery on your spine?  Yes  No
- Do you have hyperparathyroidism?  Yes  No
- Do you take thyroid medication?  Yes  No
- Have you ever taken prednisone or other steroids?  Yes  No
- Are you on hormone replacement therapy?  Yes  No
- Do you have a personal history of osteoporosis?  Yes  No
- Are you being treated for osteoporosis? \*  Yes  No

\*If yes, what osteoporosis medication are you taking? .....

**ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION**

I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for the non-covered services including any deductibles or co-payments I might owe. I also authorize the physician to release any information required to process this claim.

Patient Signature: ..... Date Signed: .....

Patient/Guardian Signature: .....

**FOR OFFICE USE ONLY**

733.00                      733.90                      V49.81                      V67.59                      V58.69

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