WOMEN'S CARE SPECIALISTS, P.C.
2006 Brookwood Medical Center Drive
Women's Medical Plaza • Suite 600
Birmingham, Alabama 35209
205.877.2971 • fax 205.877.2964
wcspc.com

Dr. Janet A. Davis
Dr. Karla G. Kennedy

Dr. Elizabeth A. Barron
Dr. Margot Gathings

Date: ________________

Patient Name (print): ________________________________ MR# ______________

Date of Birth: _____/ ______/ _______ Doctor: ____________________

Ethnicity (circle one): White African American Hispanic Asian Other: ______________

Ordering Diagnosis: Dexa ____

Answer the questions by circling the appropriate responses (yes, no, don't know) to the right. If your answer is "Yes", enter additional information beside the question.

Gynecologic History:

- Have you gone a year or more without a period? Yes No Don't Know
- Have your ovaries been removed? Yes No Don't Know
- Have you entered Menopause? If Yes, what age? ______ Yes No Don't Know

Medications:

- Are you taking hormone replacement pills or using patches? Yes No Don't Know
- Have you ever taken, or do you now take thyroid medication, Cortisone, Prednisone, or other steroids? Yes No Don't Know
- Are you currently taking calcium and/or Vitamin D? Yes No Don't Know

Lifestyle:

- Do you smoke cigarettes? If yes, packs/ day _______ Yes No Don't Know
- Do you drink alcoholic beverages? If yes, drinks/day ________ Yes No Don't Know
- Do you exercise regularly? Yes No Don't Know

Fractures and Falls:

- Have you ever broken any bones? Yes No Don't Know
  Year: _______ Site: ____________ How: ________________
  Year: _______ Site: ____________ How: ________________

History of Osteoporosis and back pain:

- Does anyone in your immediate family have Osteoporosis, If yes (circle) Yes No Don't Know
  Mother Father Sister(s) Brother(s)

List of Current Medications:

____

____

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Dear Patient:

As part of your medical care your physician may recommend certain procedures or tests that may not be covered by your insurance company. Your physician will not order test that in his or her professional opinion are not absolutely necessary. It is your right, as a patient, to decline any or all such testing.

The Test(s) ordered for you today is: **BONE DENSITY.**

FINANCIAL RESPONSIBILITY WAIVER

By signing this waiver I accept full responsibility for payment if the charges are denied by my insurance company. I was fully informed of the medical reason for the Test(s) being performed today and AGREE to have these Test(s) performed.

____
Patient Signature

____
Date

DECLINATION

I was fully informed of the medical reason for the Test(s) being performed today and DECLINE to have the Test(s) performed.

____
Patient Signature

____
Date

Gregg W. Thomas • Administrator