Lifespan Physician Group, Inc.
Obstetrics & Gynecology
Delivering health with care.®

BONE HEALTH PROGRAM
148 West River St.
Providence, RI 02904
(401) 606-3800
WomensMedicine.org

Dear _____,

Welcome to the **Bone Health Program.**

Your appointment with _____ is on _____

at _____ am/pm on the **FIRST floor, Suite 8.**

Please bring the completed new patient packet (enclosed), along with your insurance cards, photo ID, and current medication list.

The information requested is important for your care. We appreciate you taking the time to complete all the paperwork and bringing it with you to your appointment.

Please do not mail your packet back to us.

Please arrive 15 minutes prior to your appointment time for registration.

If you need to cancel or reschedule your appointment, we request that you do so at least 24 hours in advance.
Please call us at (401) 606-3800 if you have any questions.

Expect your first visit to be focused on your pain history. Your second visit will include a physical exam and discussion of a plan of care.
You can discuss the role of prescription pain medication at your visit. However, the doctor will not prescribe pain medication at the first visit.

Driving directions are enclosed. Park in the South parking lot. Parking is free.

We look forward to seeing you.

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DRIVING DIRECTIONS

From EAST of PROVIDENCE

- From Route 195, merge onto Route 95 North toward Providence
- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 148 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

From WEST of PROVIDENCE

- Follow Route 146 South to Providence
- Take the Admiral Street exit
- Turn left onto Admiral Street
- Turn right onto Charles Street / RI-246
- Turn left onto West River Street
- 148 West River Street is on the left (brick mill building)

Park in the South parking lot.

From NORTH of PROVIDENCE

- Follow Route 95 South toward Providence (crossing into Rhode Island)
- Take the Branch Avenue exit (Exit 24)
- Turn right onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- Turn right to stay on West River Street
- 148 West River Street is on the right (brick mill building)

Park in the South parking lot.

From SOUTH of PROVIDENCE

- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 148 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

We are located on the First Floor in Suite # 8

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Patient Label

Bone Health Program First Floor-Suite 8
148 West River Street, Providence, RI 02904

REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Last Name	First Name	Middle

Birth Date	Social Security #	Email

Street Address	Home Phone ( )

City	State	Zip Code	Mobile Phone ( )

Marital Status
❑ Single ❑ Married ❑ Divorced ❑ Legally Separated
❑ Widowed ❑ Significant Other ❑ Other:_____

Preferred Language
Spoken: _____ Written: _____
Interpreter Required? ❑ YES ❑ NO

Sex: ❑ Female ❑ Male

Religion: _____

Preferred Pharmacy: Name: Phone #:
Address:

Are you Employed? ❑ YES, Full Time ❑ YES, Part Time ❑ YES, Self-employed ❑ Student, Full Time
❑ NO, Not Employed ❑ NO, Disabled ❑ NO, Retired ❑ Student, Part Time

Employer	Occupation	Employer Phone ( )

Which provider you are here to see today?

How did you hear about us?

Primary Care Provider (PCP) / Practice Name

PCP Address

PCP Phone ( )

INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Person responsible for bill	Birth Date / /	Address (if different)	Home Phone ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary Insurance Plan Name

Group #	Policy #	Co-Pay Amount

Subscriber's Name	Subscriber's Birth Date / /	Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed

Subscriber's Employer

Name of secondary insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____	Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed	Subscriber's Employer

IN CASE OF EMERGENCY

Name of local friend or relative to contact	Relationship to patient	Home Phone ( )	Mobile Phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Miriam Hospital (Women's Medicine Collaborative) or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

PATIENT PORTAL: Would you like access to the MyLifespan Patient Portal? ❑ Yes ❑ No

ADVANCED DIRECTIVES: Do you have a Living Will? (A written document instructing your attending physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition) ❑ Yes ❑ No Do you have a Durable Power of Attorney for Healthcare? (A written declaration designating another person to be your agent) ❑ Yes ❑ No I would like the *Living Will and Durable Power of Attorney for Healthcare* booklet. ❑ Yes ❑ No

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Name:

DOB:

MRN:

ETHNICITY – PLEASE SELECT

We want to make sure that all our patients get the best care possible.
Please tell us your country of origin and racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. Your answers are confidential and will have no effect on the care you receive.

❑ Hispanic or Latino ❑ Non-Hispanic/Latino ❑ Unknown ❑ Prefer not to answer

RACE - PLEASE SELECT

❑ Unknown

❑ Prefer not to answer

❑ American Indian or Alaska Native

❑ Asian (includes Chinese, Cambodian, Hmong, Indian, Filipino, Laotian, Other Asian)

❑ Black or African American (includes Black, African American, African, Ethiopian, Ghanaian; Haitian, Cape Verdean, West Indian, Nigerian, Other African)

❑ Native Hawaiian or other Pacific Islander (includes Native Hawaiian, Pacific Islander, Guamanian)

❑ White or Caucasian

❑ Other: _____

PHONE PRIVACY

In our efforts to protect your privacy, please let us know how you would like us to reach you regarding future appointments or information regarding your healthcare.

HOME telephone # (_____) _____

MOBILE telephone # (_____) _____

WORK telephone # (_____) _____

BEST number to reach you: ❑ Home ❑ Mobile ❑ Work

May we leave a **general** message about appointments? HOME: ❑ Yes ❑ No
MOBILE: ❑ Yes ❑ No
WORK: ❑ Yes ❑ No

May we leave a **detailed** message? HOME: ❑ Yes ❑ No
MOBILE: ❑ Yes ❑ No
WORK: ❑ Yes ❑ No

Bone Health Program
148 West River St., Providence, RI 02904
1st Floor – Suite 8
(401) 606-3000

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Patient Label

PLEASE FILL OUT ALL FORMS AND BRING TO YOUR APPOINTMENT

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name: _____ First: _____ DOB: _____ /_____/_____

Ethnicity: ☐ Asian ☐ Black ☐ Hispanic ☐ White Tallest height: _____

Preferred Language Spoken: _____ Written: _____

Interpreter Required? ☐ YES ☐NO

Your Physicians

Primary Care Provider_____ Date last seen: _____

GYN Provider_____ Date last seen: _____

Other Providers/Specialists:

Name _____Specialty_____ Date last seen: _____

Name _____Specialty_____ Date last seen: _____

Name _____Specialty_____ Date last seen: _____

Which provider referred you to see us? _____

Briefly describe the reason for your referral and any current symptoms:

MEDICATIONS

Have you ever been treated for osteoporosis or low bone density/thin bones (osteopenia)? ☐ Yes ☐ No

If Yes, Please check any of the following medications that you have ever taken:

☐ Actonel (risedronate)	☐ Boniva (ibandronate)	☐ Evista (raloxifene)
☐ Forteo (parathyroid hormone)	☐ Fosamax (alendronate)	☐ HRT (estrogen/hormone therapy)
☐ Miacalcin (calcitonin)	☐ Reclast (zoledronate)	☐ Prolia (denosumab)
☐ Calcium	☐ Vitamin D	☐ Other_____

How long did you take this medication(s)? _____

Any problems with this medication(s)? If Yes, explain: _____

Have you ever taken a steroid (such as prednisone)? ☐ Yes ☐ No

Do you take a daily Multi-vitamin, Calcium or Vitamin D supplement? ☐ Yes ☐ No If Yes, how much? _____

Please list all medications you are now taking (include non-prescription drugs):

Medication	Dose	Frequency	Reason you take this

List all ALLERGIES:

Patient Label

Past Medical History (please check all that apply)

Please check any of the following conditions that you have ever had:

- ☐ Anorexia or Bulimia
- ☐ Asthma or Emphysema
- ☐ Cancer (type)_____
- ☐ Cushing's Disease
- ☐ Diabetes
- ☐ Hyperparathyroidism
- ☐ Inflammatory Bowel Disease
- ☐ Kidney Disease
- ☐ Low bone mass (osteopenia)
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Thyroid Disease (type)_____
- ☐ Other _____

Screenings

Colonoscopy: Date: _____ Result: _____

Last Mammogram: Date: _____ Result: _____

Bone Density: Date: _____ Result: _____

Menstrual History

Is there any possibility you are pregnant? ☐ Yes ☐ No

Do you have regular periods? ☐ Yes ☐ No Date of last period_____ Number of periods in last 12 months_____

Your age at menopause_____ Was this a natural menopause? ☐ Yes ☐ No

Did you have a hysterectomy? ☐ Yes ☐ No If yes, number of ovaries removed ☐None ☐ One ☐ Both

Menopause due to chemotherapy? ☐ Yes ☐ No

Fracture/Surgical History

Have you ever broken a bone ? ☐ Yes ☐ No If Yes, How old were you? _____

If yes, what was fractured? _____

How did the fracture occur?_____

Have you had any surgery for your bones, spine, or hip? ☐ Yes ☐ No

If yes, what part of your body?_____ Do you have any screws or plates in place? ☐ Yes ☐ No

Why did you have surgery?_____

Did either of your parents have a hip fracture? ☐ Yes ☐ No

Personal History

Do you smoke? ☐ Yes ☐ No Have you smoked in the past? ☐ Yes ☐ No

How many caffeinated drinks do you have in a week? _____ How many alcoholic drinks do you have in a week? _____

How many fizzy/phosphorated drinks do you have in a week? _____

Do you eat at least 3 servings of dairy products per day? ☐ Yes ☐ No

Do you exercise at least 3 times per week? ☐ Yes ☐ No

Do you have any problems with balance? ☐ Yes ☐ No

Have you fallen two or more times in the past year? ☐ Yes ☐ No

Have you fallen with injury in the past year? ☐ Yes ☐ No

Are you afraid of falling? ☐ Yes ☐ No

Menopause & Bone Health Consultation
148 West River St., Providence, RI 02904
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(401) 606-3000

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REVIEW OF SYSTEMS

Patient Name: Date of Birth:

REVIEW OF SYSTEMS: Please indicate all that apply to you.

Constitutional Symptoms	Y	N	**Head and Neck**	Y	N
Weight gain/loss			Dizziness/Vertigo		
Fevers			Double vision		
Night sweats			Any vision changes		
Daytime hot flashes			Nose bleeds		
Fatigue			Sore throat/Pain swallowing		
Loss of appetite					
Cardiac	Y	N	**Respiratory**	Y	N
Chest pain/heaviness			Cough		
Shortness of breath with activity			Wheeze		
Shortness of breath at rest			Shortness of breath		
Irregular heart beat/Palpitations			Blood in sputum		
Lightheadedness/Fainting			Early waking/Snoring		
Gastrointestinal	Y	N	**Genitourinary**	Y	N
Abdominal pain			Frequent voiding		
Nausea/Vomiting			Pain with voiding		
Heartburn			Blood in urine		
Constipation or Diarrhea			Vaginal dryness		
Blood with stools			Sexual dysfunction		
			Pain with sexual activity		
Endocrine	Y	N			
Heat/cold intolerance			**Hematologic**	Y	N
Excessive thirst			Abnormal bleeding/bruising		
Excessive voiding			Clotting problems		
Excessive appetite			Transfusion problems		
Excessive hair growth			Anemia		
			Blood clots		
Musculoskeletal	Y	N			
Joint pain/swelling			**Neuro-Psychiatric**	Y	N
Stiffness			Seizures		
Weakness of limbs			Numbness		
Back pain/Sciatica			Weakness		
Gout			Depression		
			Anxiety		
Ob-Gyn	Y	N			
Pregnancies If yes, how many?			**Breast Health**	Y	N
Live births If yes, how many?			Breast cysts/lumps		
C-section If yes, how many?			Breast skin changes		
Menstrual period regular			Nipple discharge		
Postmenopausal Last Period:			Breast pain		
Postmenopausal bleeding			Recent mammogram		
Recent PAP Smear					

Provider Notes
Please do not write in this area.

Thank you for providing us with this important information.

Patient's Signature: _____ Date: _____