

NAME: _____ APPT DATE: _____ TIME: _____

REFERRING MD: _____

() MAILED HISTORY FORM: _____

() RECEIVED HISTORY FORM _____

() RECEIVED MD REFERRAL _____

() DEXA ALSO

() PATIENT TOLD TO COME 1/2 HOUR EARLY TO COMPLETE FORMS

NOTE ***We Are a "FRAGRANCE FREE OFFICE"***

Last Initial

We are a "FRAGRANCE FREE OFFICE"

Please see our Office Policy for Details.

Dear _____ Appointment Date: _____, 2026 ____ am ____ pm

With: Dr. Robin K. Dore Dr. Farshid Bozorgnia

You are scheduled for an appointment. **These are our policies:**
See our “Fragrance Free” Office Policy
Referral required.

You must have a **referral** from your **treating physician** stating the reason for the referral. This can be a faxed prescription referring you to this office.

This office only provides **adult** (usually 30 and older) **rheumatology care** for arthritis and related auto-immune diseases; osteoporosis care may also be provided. **Patients are not seen for** “second opinions.”

You **must** have a **primary physician** for your general medical (and emergency) care as well as routine physical exams. For example, your primary physician is responsible for your routine screening for various diseases, such as for breast, cervical, colon and prostate cancer. Breast, genitourinary and rectal examinations are not performed by Dr. Dore and/or Dr. Bozorgnia as part of their rheumatology care.

Forms to complete.

Fully complete, sign and return a **week** prior to your appointment the enclosed: patient history, financial responsibility statement and insurance billing authorization. We reserve the right to cancel appointments if the forms have not been received.

Bring/Send medical records.

Bring/Send any lab results, x-ray reports or other information relating to your disease. Ask your doctor in writing to send records here. Records may be sent via fax or email: info@robinkdoremd.com

Payment.

Payment in full is required at the time services are rendered for any **“Out of Network”** Patient. You will receive a receipt showing the treatment, charge and diagnosis. You can use this to seek insurance reimbursement. **Medicare and Blue Shield of California** PPO(Commercial Plans) patients are responsible for deductibles and co-payments deemed by your insurance company as Patient Responsibility – these are paid at visits.

Credit Cards Accepted: Visa, AMEX and MasterCard **ONLY.**

Insurance billing.

Except for Medicare and Blue Shield of California PPO (Commercial Plans Only). Dr Dore and/or Dr. Bozorgnia are **NOT a Preferred Provider for any Blue Shield PPO “Individual/Family Plans” -IFPs**, we do not bill insurance except as a courtesy – and only to those insurers we already submit to electronically.

Patients are responsible for amounts not paid by their insurer for medical services. **Medicare** patients please note: We may bill your secondary insurance(s). You may have to pay any amount not paid by your secondary insurance(s).

Artificial Intelligence (AI): We may utilize an AI-assistant scribe for documentation during your office/virtual visit. There will be verbal consent to utilize the AI-assistant during the visit, but you may opt-out at any time.

Communication: Our office may communicate with our patients by telephone and/or electronic methods, such as our: **Patient Portal.**

Please Bring Your Insurance Card(s) to your appointment.
If you are faxing/mailing your completed New Patient Packet, please include your insurance card(s) with your forms.

No IPAs/HMO/“Senior” Plans/ PPOs/Covered CA/Exchange.

This office is **NOT** a member of **any** independent physician organization (IPA), HMO, “senior plan” or preferred provider organization (PPO) or ANY Covered CA/Exchange Plans. **Exception: Blue Shield of CA PPO (Commercial Plans-ONLY).** Dr. Dore/Dr. Bozorgnia are considered **“Out of Network”** for all Blue Shield of CA **“Individual/Family Plans”**, eg, Platinum, Gold, Silver Plans, etc... **It is the patient’s responsibility to call and confirm with their own insurance plan to confirm.**

No Primary Medi-Cal, Medicare/Medi-Cal, or Cal Optima

This office does **not** see Patients with these coverages. We reserve the right to stop seeing Medicare patients if their Medicare becomes secondary.

No Workers' Compensation or accident / lawsuits.

This office also does not see new patients with injuries, job related or otherwise, or problems which may involve a pending or potential lawsuit.

Any new patient with an injury, accident or problem involving an existing or potential lawsuit or workers compensation claim will not be seen and any visit will be terminated upon disclosure of such matters.

*****Please: Do not wear anything scented (perfume, cologne, body powder, after shave lotion, etc.) to the office.** Dr. Dore is **highly allergic** to these items. If you wear any such items your appointment may be canceled. You would have to reschedule. **See our “Fragrance Free” Office Policy.**

Cancellations. If you cannot keep this or any other appointment, please advise us as early as possible. We reserve the right not to reschedule patients who cancel.

Call **the office** if you have any questions about our policies.
714-505-5500. email: info@robinkdoremd.com

Full payment is required from you at the time of the office visit for all Primary insured **“Out of Network”** Patients. Blue Shield of CA Plans, Medicare and Medi-Cal patients must pay any applicable deductible, co-payment or share of cost.) We are **NOT** a member of any preferred provider organization (except Dr. Dore is a California Blue Shield PPO preferred provider for **Commercial Plans only**) or independent physician association (IPA) or HMO. We will file primary Medicare claims. We will bill third party coverage as a courtesy if already do so electronically. However, you are responsible for any amount not paid except where applicable federal or state laws limit patient’s responsibility.

Name		Cell / Mobile No:	
Address		Home No:	
City		Last 4 of SSN	Sex:
State/Zip		Birth Date	
Marital	() Single () Married () Divorced () Widowed/Widower		
Patient Employer	Patient e-mail address:		
Spouse	Primary Pharmacy Name/Phone:		
Spouse Employer		Spouse Work Tel	
Friend/relative (other than spouse) to call in emergency:			
Friend/relative Tel		Relationship	
Primary Insurance		Secondary Ins	
Policy No		Policy No	
Group No		Group No	
Policyholder		Policyholder	
Primary MD		Tel	
Orthopedist		Tel	
Gynecologist		Tel	
Other		Tel	

Adult (usually 30 or older) rheumatology consultation and treatment are provided solely for arthritis and related auto-immune diseases; osteoporosis care is provided for some patients. Therefore, it is required that all patients have a primary care physician (internist, family or general practitioner) and appropriate specialists for their other medical problems and for emergencies.

You must see your primary physician for routine physical examinations, including appropriate screening for various diseases, including screening for breast, cervical, colon and prostate cancer, all of which can be fatal if undetected. Breast, genitourinary and rectal examinations are not performed by our physicians as part of providing rheumatology care.

We encourage you to discuss fees prior to your appointment to avoid any misunderstandings.

Our fees are for Rheumatology consultation and care and for any x-ray or lab services done in our office. Any additional studies (lab, xray, EMG, MRI, CT scan, etc.) not done in our office will be billed directly to the patient by the appropriate outside lab, physician or x-ray facility that does those tests.

AGREED TO:

Patient Sign:

Date: _____

Robin K. Dore, MD, Inc.

INSURANCE AUTHORIZATION AGREEMENT

The patient hereby provides **Robin K. Dore, MD, Inc.** with the following authorizations relating to insurance, Medicare and/or other coverage available to the patient; such authorizations shall apply to past, present and future services furnished by **Robin K. Dore, MD, Inc.**

Authorization of Payment of Benefits

I authorize payment directly to: **Robin K. Dore, MD, Inc.**, for services furnished to me. I will pay all charges not fully paid by insurance, Medicare and/or other coverage. I authorize release of my insurance information to a lab or other outside facility so they can bill my insurance directly for their services.

Signature: _____ Date: _____

Authorization to Release Information

I authorize, **Robin K. Dore, MD, Inc.** (and all physicians employed thereby) to release any information acquired in the course of my examination and treatment to my insurer, Medicare and/or provider of other coverage.

Signature: _____ Date: _____

(1) Medicare Authorization and (2) Medicare Authorization for Prolonged Treatment (YE 12/31/2026) and (3) Addendum

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to: **Robin K. Dore, MD, Inc.** for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier.

Medicare Authorization for Prolonged Treatment (YE 12/31/2026)

I request that payment under the medical insurance program be made either to me or to **Robin K. Dore, MD, Inc.** on any bills for services furnished me by **Robin K. Dore, MD, Inc.** and/or **Robin K. Dore, MD** and/or **Farshid Bozorgnia, MD** during the period **OCTOBER 1, 2025 TO DECEMBER 31, 2026.**

Medicare HMO Addendum

I know that Robin K. Dore, MD is **NOT** a member of any Medicare HMO and if I belong to or sign up for a Medicare HMO, I must pay Robin K. Dore, MD for her services. It is my choice to see Dr Dore and/or Dr. Bozorgnia (and pay) or go to a rheumatologist on my HMO plan.

MEDICARE No: _____

Signature: _____ Date: _____

Group: Robin K. Dore , M.D., Inc.

HEALTH HISTORY QUESTIONNAIRE FOR PATIENTS SEEKING TREATMENT FOR ARTHRITIS AND RELATED DISEASES

Appointment Date:		Time:		Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other:		Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic	
Name:			Age:		Date of Birth:		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Referred by: <input type="checkbox"/> Self <input type="checkbox"/>				who is <input type="checkbox"/> MD <input type="checkbox"/> Friend <input type="checkbox"/> Health professional <input type="checkbox"/> Other			
Your primary physician:				The names of your other types of doctors listed below			
Orthopedic Surgeon <input type="checkbox"/> None <input type="checkbox"/>				Gynecologist <input type="checkbox"/> None <input type="checkbox"/>			
Date of Last →		Physical Exam:		Chest X-ray:		Pap Smear:	
Dental Exam:		Lab Tests:		Eye Exam:		Mammogram:	

- Yes No Is your problem work related?
- Yes No Do you have any injury, accident or problem - with an existing or potential lawsuit?
- Yes No Are you receiving or applying for disability?
- Yes No Are you receiving or applying for workers compensation?

HISTORY OF PRESENT PROBLEMS: What Brings you to a Rheumatologist?

Began: _____ **Describe your symptoms**

COVID-19 History: _____ **Describe your symptoms:**

Joints: <input type="checkbox"/> Swelling		<input type="checkbox"/> Pain when move	Muscles: <input type="checkbox"/> Pain when used		<input type="checkbox"/> Weakness	<input type="checkbox"/> Tender to touch
<input type="checkbox"/> Tender to touch		<input type="checkbox"/> Reduced movement	Morning stiffness - for how long: _____			
Joints affected in the last 6 months: _____						
Muscles affected in the last 6 months: _____						
Who have you seen for this problem? <input type="checkbox"/> No one						
Have you seen a rheumatologist ?		<input type="checkbox"/> No	Who?		When?	
Were you given a diagnosis?		<input type="checkbox"/> No	What?		When?	

WHAT TREATMENT DID YOU HAVE?	Was it Effective?	Was it Effective?	Was it Effective?
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medication (List pages 3 and 4)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Appliance (cane, walker)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Psychological counseling	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Surgery (List next page)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Joint injected or Aspirated	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Trigger point injection	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No

WHAT IS YOUR MEDICAL HISTORY?	Do you have, or have you had, any of the following problems? (Check which ones) List any other problems not mentioned.		
<input type="checkbox"/> AIDs or Aids related complex	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Kidney disease/stones	<input type="checkbox"/> Thyroid disease <input type="checkbox"/> Hypothyroid
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Hyperparathyroid
<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mental health problems	<input type="checkbox"/> Inflammatory bowel disease
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Gout	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Inflammatory Eye disease (Iritis, uveitis, episcleritis)
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Headaches	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Positive TB Skin test
<input type="checkbox"/> Cancer :	<input type="checkbox"/> Heart disease/heart attacks	<input type="checkbox"/> Pleurisy/fluid on lungs	<input type="checkbox"/> Tuberculosis (TB)
<input type="checkbox"/> Congestive heart failure:	<input type="checkbox"/> Hepatitis/Jaundice	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers Bleeding? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Strokes <input type="checkbox"/> Psoriasis	<input type="checkbox"/> Venereal disease
Please list any other medical problems not mentioned:			<input type="checkbox"/> Rheumatic fever
			<input type="checkbox"/> Long COVID

WHAT IS YOUR SURGICAL HISTORY?

Have you had any of kind of surgery, in or out of a hospital? **Yes** **No** If yes, describe the surgeries below.
Surgery includes plastic/cosmetic surgery or procedures (breast implants, collagen injections, lifts, tucks, etc.)

What operation was performed:	When:	Who performed the operation:	Where?

Have you ever had any

Broken bones or fractures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When?	Which bone?
Other major injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When?	Describe
Transfusions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When?	Where?

WHAT IS YOUR FAMILY MEDICAL HISTORY?

Father <input type="checkbox"/> Alive/age	Current health	<input type="checkbox"/> Dead/ age died	Cause of death
Mother <input type="checkbox"/> Alive/age	Current health	<input type="checkbox"/> Dead/ age died	Cause of death
Number of Brothers	Number alive	Number dead	Age died
Number of Sisters	Number alive	Number dead	Age died
Number of Children	Number alive	Number dead	Age died
Ages of Living Children			
Major illnesses of Children			

Has any blood relative (parent, grandparent, aunt, uncle, sibling, child, etc.) had any of the following conditions?

Check if yes	Relation	Check if yes	Relation
<input type="checkbox"/> Ankylosing spondylitis	_____	<input type="checkbox"/> Cancer:	_____
<input type="checkbox"/> Arthritis (type unknown)	_____	<input type="checkbox"/> Cancer:	_____
<input type="checkbox"/> Childhood arthritis	_____	<input type="checkbox"/> Cancer:	_____
<input type="checkbox"/> Colitis	_____	<input type="checkbox"/> Congestive heart failure	_____
<input type="checkbox"/> Fibromyalgia	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> Lupus or SLE	_____	<input type="checkbox"/> Heart problems	_____
<input type="checkbox"/> Osteoarthritis	_____	<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Osteoporosis	_____	<input type="checkbox"/> Kidney disease/stones	_____
<input type="checkbox"/> Psoriasis	_____	<input type="checkbox"/> Leukemia	_____
<input type="checkbox"/> Rheumatoid arthritis	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Other arthritis condition	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Alcoholism	_____	<input type="checkbox"/> Thyroid problems	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Tuberculosis (TB)	_____
<input type="checkbox"/> Bleeding tendency	_____	<input type="checkbox"/> Ulcer	_____
		<input type="checkbox"/> Inflammatory Eye disease	_____

Please list any other family medical problems not mentioned.

REVIEW OF SYSTEMS: Check which symptoms apply to you; please complete any blanks.**GENERAL**

- Fatigue
- Chronic Yes No
- Recent Yes No
- Weakness
- Generalized Yes No
- Local Yes No
- Where? _____
- Fever Yes No
- High? Yes No
- How often? _____
- Recent weight change Yes No
- How much? _____ Gain Loss
- Loss of appetite Yes No
- Thirst Yes No

SKIN

- Bruise easily Yes No
- Rash Yes No
- Redness Yes No
- Hives Yes No
- Tightness Yes No
- Hair loss Yes No
- Dry Yes No
- Nodules/Bumps Yes No
- Sensitive or allergic to sunlight Yes No
- Hands/feet change color in cold Yes No
- Increased pigmentation Yes No
- Decreased pigmentation Yes No
- Ulcerations (sores) Yes No

EARS

- Ringing in ears Yes No
- Hearing loss/impaired Yes No

EYES

- Painful Yes No
- Red Yes No
- Dry Yes No
- Loss/impaired vision Yes No
- Double or blurred vision Yes No
- Feels like something in eye Yes No

NOSE

- Nosebleeds Yes No
- Loss/impairment of smell Yes No
- Dry Yes No

MOUTH

- Sore tongue Yes No
- Gums bleed Yes No
- Sores in mouth Yes No
- Loss/impairment of taste Yes No
- Dry Yes No
- Yeast in mouth Yes No

THROAT

- Frequent sore throats Yes No
- Hoarse Yes No
- Hard to swallow Yes No

NECK

- Swollen glands Yes No
- Tender glands Yes No

HEART and LUNGS

- Chest pain Yes No
- Heart murmur Yes No
- Irregular heart beat Yes No
- Sudden changes in heart beat Yes No

- Shortness of breath Yes No
- Wheezing Yes No
- Difficulty breathing at night Yes No
- Cough up blood Yes No
- Coughing Yes No

- Swollen legs, ankles or feet Yes No
- High blood pressure Yes No
- Night sweats Yes No

STOMACH and INTESTINES

- Nausea Yes No
- Heartburn Yes No
- Indigestion Yes No
- Stomach pain relieved by food, milk or antacids. Yes No
- Blood in stools Yes No
- Black stools Yes No
- Vomit blood or coffee ground-like material Yes No
- Jaundice/yellow skin Yes No
- Constipation Yes No
- Diarrhea Yes No

KIDNEY/URINE/BLADDER/GENITALS

- Have difficulty trying to urinate Yes No
- Pain or burning when urinating Yes No
- Blood in urine Yes No
- Pus in urine Yes No
- Urine is cloudy or "smoky" Yes No

- Discharge from penis or Yes No
- Have to urinate frequently Yes No
- Must get up at night to urinate Yes No

- Vaginal dryness Yes No
- Genital rash/ulcers Yes No
- Herpes Yes No

- Prostate problems Yes No
- Sexual activities limited Yes No
- By disease Yes No
- Other reasons Yes No

BLOOD

- Anemia Yes No
- Bleeding tendency Yes No

NERVOUS SYSTEM

- Headaches/Where
- Front of head Yes No
- Back of head Yes No

- Dizziness/When
- All the time Yes No
- When changes positions Yes No
- Fainting Yes No
- Loss of consciousness Yes No
- When? _____

- Memory loss – can't remember
- Recent activity Yes No
- Old events Yes No

- Muscle spasm
- Generalized Yes No
- Localized Yes No
- Where? _____

- Sensitivity or pain due to cold
- In hands Yes No
- In feet Yes No

- Numbness/tingling
- Hands Yes No
- Arms Yes No
- Feet Yes No
- Legs Yes No
- Coordination problems Yes No

- Do you have difficulty
- Relaxing Yes No
- Concentrating Yes No
- Deciding things Yes No
- Are you: Nervous Yes No
- Depressed Yes No
- Worried a lot Yes No
- Losing your temper Yes No
- Anxious Yes No

MENSTRUAL HISTORY

[] N/A, male

Age periods began _____ Lasting how long _____ Days apart _____

Age periods ended _____

Month/year of: Last Menstrual period _____

Month/year of: Last bleeding of any kind _____

Yes No Do you consider yourself postmenopausal. If yes, was it
 Natural menopause Surgical menopause (hysterectomy)
 Yes No Were one or more ovaries removed?

Yes No Are/were your periods regular
Were your periods infrequent or absent:

Yes No For one or more years

Yes No Because of athletic participation (running, gymnastics, diving, etc.)

Yes No Have you ever used contraception. If yes, describe:
Current: _____
Past: _____

Yes No Have you ever taken estrogen therapy (ERT/HRT)?
If yes, date started: _____ Date stopped: _____
If no, why not? _____

Current ERT/HRT: _____

List all previous ERT/HRT: _____

If you stopped, ERT/HRT, why?

OSTEOPOROSIS PROFILE QUESTIONS

Sex/Race: Female Male White Asian Hispanic Black Other :

Age/Ancestry: Age _____ N Europe Scotch Irish English

Height Changes: Maximum Height: _____ Height today: _____

Weight Changes: Weight at 20: _____ At 50 _____ Today _____

Yes No Have you been told you have osteoporosis?
 Yes No Have you been told your x-ray shows low bone mass?
 Yes No Have you ever had a bone density study? If yes, was it:
 Spine Hip Wrist Ankle
When: _____ Where: _____

Yes No Have you ever had a CT scan of your spine or hip

Yes No Have you broken any bones? Which ones:
 Spine Hip Wrist Ankle
 Rib Toe Other _____

Yes No Have you taken any of the medicines below? Which ones:
 Fosamax Actonel Evista ERT/HRT
 Calcitonin Fluoride Didronel

Yes No Do you have a family history of osteoporosis?
 Mother Daughter Sister Grandmother
 Father Son Brother Grandfather

Yes No Did any family members with osteoporosis have a fracture?
 Mother Daughter Sister Grandmother
 Father Son Brother Grandfather

Yes No Do you have scoliosis (curvature of the spine)?

Yes No Do you have any of these physical characteristics?
 Petite/small build (8 or less dress/36 or less jacket)
 Light hair, fair skin, freckles when young

Yes No Are you/have you been inactive, immobile or confined indoors?
 Yes No Do you have/did you have an eating disorder?
 Anorexia Bulimia Other

Yes No Do you/did you smoke more than 1 pack /cigarettes day?

Yes No Do you/did you drink 2 or more alcohol beverages a day?

Yes No Do you/did you drink 2 or more caffeine beverages a day?

Yes No Was your dairy product use limited for any reason?
 Allergic Caused cramps or stomach upset
 Consumed 2 or less milk products day

Yes No Do you/did you taken any of the following medications:
 Prednisone/Medrol Dilantin
 Chemotherapy Heparin/Coumadin
 Methotrexate Lupron
 Thyroid supplements Lithium

Yes No Do you/did you have any of the following health problems:
 Gastric surgery Asthma
 Epilepsy Breast Cancer
 Rheumatoid arthritis GI/Bowel disease
 Liver problems Prostate cancer
 Thyroid supplements Infertility
 Kidney diseases Malabsorption syndrome
 Juvenile diabetes Transplant recipient

No Yes Did you breast feed any children?

No Yes Do you take calcium supplements?

No Yes Do you take a multivitamin or Vitamin D supplement?

No Yes Are you physically active?
 Jog Walk frequently Swim Other

Robin K. Dore, MD, Inc.

Providers: Robin K. Dore, MD; Farshid Bozorgnia, MD

Authorization For Use or Disclosure of Protected Health Information

I hereby authorize **X** _____ (the "Health Care Provider") to use and disclose health information concerning the following patient:

X _____ as follows:

Health information to be used or disclosed: Any and all health information other than psychotherapy notes may be disclosed, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically written below:

[optional] _____

Disclosure may be by means such as, but not limited to, providing copies of the records containing patient's health information, faxing such records and/or by allowing inspection and/or copying of such records

This health information may be disclosed to: Robin K. Dore, M.D., Inc.

Robin K. Dore, M.D and/or

Farshid Bozorgnia, M.D

12791 Newport Ave., Suite 201 Tustin CA 92780 Tel: 714 505 5500 Fax: 714 505 3381

who may use this information only for the following purposes written below – **examples**, medical care, insurance, at the request of the individual, etc.

X _____

I understand that I may revoke this authorization at any time by notifying the Health Care Provider in writing. My revocation will not affect actions taken by the Health Care Provider in reliance on this authorization prior to receipt of my revocation.

I understand that after the Health Care Provider discloses this health information to another person or entity, federal law (the HIPAA Privacy Rule) may no longer protect the privacy of this health information and it might be further disclosed.

Effect of Refusal to Sign Authorization: I understand that my (or the patient's named above if I am not the patient) health care treatment or benefits will not be affected whether I sign or do not sign this form.

This authorization is effective now. It expires on the following date: _____ if not revoked sooner. If no date is written in this blank, this authorization expires **1 year** after the date this authorization is signed.

I understand that I have the right to receive a copy of this authorization.

Signed: **X** _____ Print Name: **X** _____

Dated: **X** _____ Relationship if not Patient: _____

Authorization: Records to: Robin K. Dore, MD, Inc.