Shore Nephrology, P.A.

www.shorenephrology.com

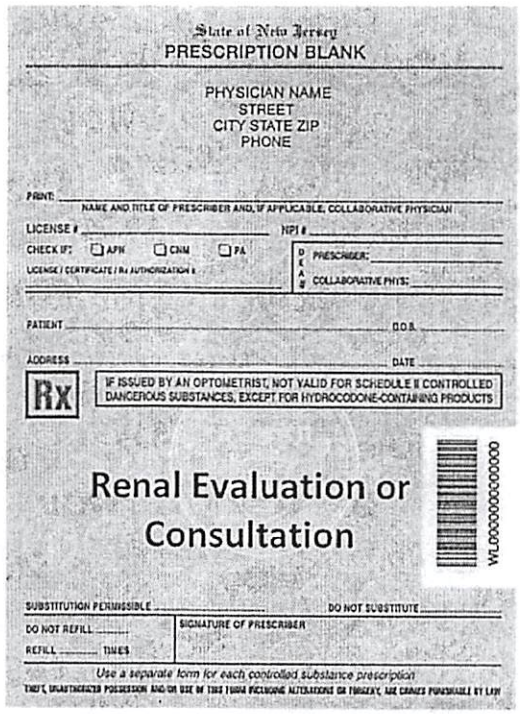
* Diplomate American Board of Internal Medicine and Nephrology
† Diplomate American Board of Critical Care Medicine

AVAIS MASUD, M.D.*†
DIONISIO V. CRUZ, M.D.
HARRY DOUNIS, D.O.*
CARLOS PALANT, M.D.*
IRA M. STRAUSS, M.D.*
MOHAMMAD U. ZAFAR M.D.*

Welcome to our practice

Please bring your insurance cards, recent medication list, recent testing i.e. blood and urine test, renal scans/ultrasounds, insurance referrals (if necessary) and a prescription from your referring physician see example below).

This appointment is for a new patient evaluation, which will take approximately 1 hour. If you are unable to keep this appointment, kindly give our office a 24-hour notice so we can reschedule.


State of New Jersey
PRESCRIPTION BLANK

PHYSICIAN NAME
STREET
CITY STATE ZIP
PHONE

PRINT: NAME AND TITLE OF PRESCRIBER AND, IF APPLICABLE, COLLABORATIVE PHYSICIAN

LICENSE # NPI #

CHECK IF: ☐ APN ☐ CNM ☐ PA

LICENSE / CERTIFICATE / Rx AUTHORIZATION #

DEA # PRESCRIBER:

COLLABORATIVE PHYS:

PATIENT D.O.B.

ADDRESS DATE

Rx

IF ISSUED BY AN OPTOMETRIST, NOT VALID FOR SCHEDULE II CONTROLLED DANGEROUS SUBSTANCES, EXCEPT FOR HYDROCODONE-CONTAINING PRODUCTS

Renal Evaluation or Consultation

SUBSTITUTION PERMISSIBLE DO NOT SUBSTITUTE

DO NOT REFILL

REFILL TIMES

SIGNATURE OF PRESCRIBER

Use a separate form for each controlled substance prescription

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW

Thank you,

Your appointment is scheduled for: _____

Date: _____ Time: _____

Office: _____

2100 Corlies Ave., Suite 15
Neptune, NJ 07753
Tel: 732-988-8228 • Fax: 732-774-1528

55 Schanck Rd., Suite B-1
Freehold, NJ 07728
Tel: 732-303-9390 • Fax: 732-414-1891

35 Beaverson Blvd., Suite 5C
Brick, NJ 08723
Tel: 732-451-0063 • Fax: 732-451-0071

27 South Cooksbridge Rd., Suite 211
Jackson, NJ 08527
Tel: 732-987-5990 • Fax: 732-987-5994

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a Privacy Rule (HIPPA) to help ensure that personal health care information is protected for privacy. This rule was also created to provide a standard for certain health care providers to obtain their patient's consent for used and disclosures of health information about the patient to carry out treatment, payment or healthcare operations.

As our patient, we want you to know that we respect the right of your personal medical records. We will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When necessary, we provide the minimum information to only those we feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical record. We may have indirect treatment relationships with you (such as labs that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your Personal Health Information (PHI) but this must be in writing. Under law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information.

Print Name:_____ Signature:_____ Date:_____

PATIENTS COMPLIANCE ASSURANCE NOTIFICATION

The misuse of Personal Health Information has been identified as a national problem causing patients inconvenience. We want you to know that all of our staff undergoes training so that they may understand and comply with government rules and regulations concerning HIPPA. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, law and regulations. We want to ensure that our proactive never contributes in any way to the growing problem of improper disclosure of PHI.

Our policy is to listen to your employees and our patients without any though of penalization if they feel that an even in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

We thank you for being one of our highly valued patients.

Shore Nephrology, PA

PATIENT INFORMATION

Patient Name: (First) _____ (Middle) _____ (Last) _____

Birth Date: _____ Sex: Male Female Marital Status: Single Married Divorced Widowed

Social Security #: _____ Preferred Language: _____

Race: ___ American Indian/Alaska Native ___ Asian ___ Black/African American

___ Native Hawaiian/ Other Pacific Islander ___ White ___ Prefer Not to Answer

Ethnicity: ___Hispanic/Latino ___ Not Hispanic/Latino ___ Prefer Not to Answer

Address: (Street) _____ (City/State)_____(Zip)_____

Home or Primary Phone#: _____ Cell or Alternate Phone#: _____

Email: _____ Employment Status: _____

Emergency Contact: (Name/Relationship) _____ Phone:_____

REFERRAL INFORMATION

Referring Physician: (Name) _____ Phone: _____ Fax: _____

Primary Care Physician: (Name) _____ Phone: _____ Fax: _____

INSURANCE INFORMATION

Primary Insurance Co. Information: (name, address, and phone # of person responsible for payment)

Insurance Company Name: _____

Policy/ID Number: _____Group Number: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's DOB: _____ Subscriber's Social Security Number: _____

Subscriber's Address: _____ Phone: _____

Subscriber's Employer: _____

Secondary Insurance Co. Information: (name address, and phone # of person responsible for payment)

Insurance Company Name: _____

Policy/ID Number: _____Group Number: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's DOB: _____ Subscriber's Social Security Number: _____

Subscriber's Address: _____ Phone: _____

Subscriber's Employer: _____

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carriers and other providers.
Medicare Patients: I authorize any holder of medical or other information about me to the Centers for Medicare & Medicaid Services its agents and information needed to determine benefits for this or related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.
I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance company. In the event my account is placed in collection with any attorney or agency, I will pay collection fees and court costs incurred to the doctor in addition to my balance. A copy of this signature is as valid as the original.

Patient Signature: _____ Date: _____

Problem List

Patient Name:_____ Date:_____

Latex Allergy: Yes No Medication Allergies:_____

Please briefly describe your complaint:_____

_____

_____

Past Medical History

Patient	Yes	No	Family Member
Diabetes	☐	☐	_____
High Blood Pressure	☐	☐	_____
Heart Attack	☐	☐	_____
Irregular Heart Beat	☐	☐	_____
Heart Valve Disease	☐	☐	_____
Seizures	☐	☐	_____
Stroke	☐	☐	_____
Pneumonia/TB	☐	☐	_____
Emphysema	☐	☐	_____
Kidney Disease	☐	☐	_____
Urinary Tract Infections	☐	☐	_____
Kidney Stones	☐	☐	_____
Hepatitis	☐	☐	_____
Anemia	☐	☐	_____
Phlebitis	☐	☐	_____
Diverticulitis	☐	☐	_____
Kidney Cysts	☐	☐	_____
Cancer	☐	☐	_____
Site:_____			_____

Patient Surgical History	Yes	No		Yes	No
Kidney Stone Surgery	☐	☐	Heart Surgery	☐	☐
Bladder Surgery	☐	☐	Pacemaker	☐	☐
Prostate Surgery	☐	☐	Appendix	☐	☐
Gall Bladder Surgery	☐	☐	Eye Surgery	☐	☐
Any other surgery	☐	☐	Type:_____		

Please check YES or NO for the following:

Weight Loss	Yes☐ No☐	Cough/Weezing	Yes☐ No☐	Shortness of Breath	Yes☐ No☐
Headaches	Yes☐ No☐	Jaundice	Yes☐ No☐	Arthritis	Yes☐ No☐
Backaches	Yes☐ No☐	Easy Brusing	Yes☐ No☐	Nausea/Vomiting	Yes☐ No☐
Chest Pain	Yes☐ No☐	Blood in Urine	Yes☐ No☐	Constipation	Yes☐ No☐
Palpitations	Yes☐ No☐	Difficulty Urinating	Yes☐ No☐	Diarrhea	Yes☐ No☐
Dizziness	Yes☐ No☐	Itching	Yes☐ No☐	Black/Tarry Stool	Yes☐ No☐

Patient Social History

Cigarette Smoker	Yes☐	No☐	If Yes, how often?_____
Cigar/Pipe Smoker	Yes☐	No☐	If Yes, how often?_____
FORMER smoker	Yes☐	No☐	If Yes, how long and when did you quit?_____
Alcohol use	Yes☐	No☐	If Yes, how often and how many drinks?_____

MEDICATION LIST

PATIENT NAME: _____

DATE OF BIRTH: _____

Medication	Dosage	Frequency

PHARMACY INFORMATION

PATIENT NAME: _____

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE #: _____

PHARMACY FAX#: _____