Shore Nephrology, P.A.

www.shorenephrology.com

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

HARRY DOUNIS, D.O.* IRA M. STRAUSS, M.D.* AVAIS MASUD, M.D.*†
SARA HUSAIN, M.D. CARLOS PALANT, 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).

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
DEA # PRESCRIBER:
LICENSE / CERTIFICATE / Rx AUTHORIZATION # 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

WL0000000000000

SUBSTITUTION PERMISSIBLE DO NOT SUBSTITUTE
DO NOT REFILL SIGNATURE OF PRESCRIBER
REFILL TIMES
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

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.

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

1000 West Main Street, Suite 3, 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

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: _________________

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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 use and disclosures of health information about the patient to carry out treatment, payment, or health care 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 physician and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care 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: ________

PATIENT'S COMPLIANCE ASSURANCE NOTIFICATION

The misuse of Personal Health Information has been identified as a national problem causing patient's 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, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI.

Our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event 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.

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?________________

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MEDICATION LIST

PATIENT NAME: ______________________________

DATE OF BIRTH: ______________________________

Medication	Dosage	Frequency

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PHARMACY INFORMATION

PATIENT NAME: ______________________________

PHARMACY NAME: ______________________________

PHARMACY PHONE #: ______________________________

PHARMACY FAX#: ______________________________

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