Paul Friedman, M.D.
Frederick J. Potulski, M.D.
Cornelius T. Gallagher, M.D.
Gustavo E. de la Luz, M.D.
Eric J. Costanzo, D.O.
Mohamed Elsawaf, M.D.
Rana Ali, M.D.
John D. Mikhail, M.D.
James Cosentino, D.O.
Ahmad Abu Homoud, M.D.
Ghadier Al Saoudi, M.D.
Noor Salam, M.D.
Matthew Frank, M.D.

Welcome to Shore Pulmonary!

Thank you for choosing us to partner with you regarding your pulmonary issues, sleep medicine and critical care needs. We have 4 convenient office locations in Monmouth and Ocean Counties: Ocean, Manasquan, Brick and our newest location in Rumson.

The following forms and requests are needed to ensure a smooth transition into our practice. Please complete all forms and bring them with you to your appointment. We ask that you arrive 20 minutes prior to your scheduled appointment time. You will need the following items:

- Valid photo ID
- Insurance Card(s), including RX card
- Referral, if required
- Your completed paperwork
- Co-Pay, if required
- Any recent radiology of the chest (CT-Scan, X-ray), Cardiology workup, blood work or Sleep Studies

If you are unable to keep your appointment, kindly give us 24 hours' notice allowing us to accommodate other patients.

Note: If you are coming to the office for either a Workers' Compensation Claim or Motor Vehicle Claim, you must contact the office prior to your scheduled appointment, for additional instructions.

Our office locations and brief directions are listed below.

Ocean 301 Bingham Avenue Ocean, NJ 07712	Located on the Asbury Circle Take Route 35 to the Asbury Circle, follow the circle around just past Enterprise Car Rental. Make the 2nd right. We are in the two-story brick building.
Manasquan 2640 Hwy 70, Bldg 6A Manasquan, NJ 08736	Located in the Brielle Hills Professional Plaza, off of Route 70 To use GPS, enter BRIELLE as the city. Traveling North on Route 70, make a right into the office park. Traveling South, go past Jersey Mikes on the right and take the next jug handle for a u-turn, follow above directions.
Brick 1608 Route 88 Suite 117 Brick, NJ 08724	Located off of Route 88. From Route 70, follow signs for Route 88 West. After passing the entrance to Ocean Medical Center (hospital). Take the next driveway on the right, we are located in the first building (closest to Route 88) Suite 117.
Rumson 108 Avenue of Two Rivers Rumson, NJ 07760	Located at the corner of Ridge Road and Avenue of Two Rivers. We are across the street (Avenue of Two Rivers) from the Oceanic Library. Parking lot entrance located on Ridge Road.

This is a fillable PDF file.
This file does *NOT* automatically save or print to Shore Pulmonary.

You can complete the form and save it to your computer. Once it is saved you can: print the document and bring it with you to your appoint, fax it to us at 732-575-1107 or:

You can attach this file to an email, along with any insurance cards, vaccination cards, testing/records or anything else you feel we may need and send them to print in our office. Email to: ShorePulmonaryForms@gmail.com

■ 2640 Highway 70
Bldg. 6A
Manasquan, NJ 08736
732-528-5900

■ 301 Bingham Avenue
Suite B
Ocean, NJ 07712
732-775-9075

■ 1608 Route 88
Suite 117
Brick, NJ 08724
732-575-1100

■ 108 Ave of Two Rivers
Rumson, NJ 07760
732-775-9075

VOICE: 732-575-1100
FAX: 732-575-1107

www.ShorePulmonary.com

Shore Pulmonary Office Information Sheet

Our business hours are Monday-Friday 9:00am – 5:00 pm.

To change or cancel an appointment call: 732-575-1100 option 2. Our Fax is 732-575-1107.

Our physicians answer messages while in the office, however, they will respond as time permits, either between patients or after regular business hours.

Patients are seen by appointment time, not by arrival time.

Before coming to the office, if you have recently (less than 2 weeks ago) tested positive for COVID-19 please contact scheduling to reschedule your appointment adhering to the most recent CDC protocols. Due to safety reasons, patients requiring breathing tests may be scheduled between 2-8 weeks out from testing positive.

Please bring your insurance card(s) and prescription card to every office visit. If your insurance requires a referral, please contact either your Primary Care Doctor or the VA for a referral prior to arriving.

If you are being seen in the office for either due to a Worker's Compensation claim or a Motor Vehicle Accident, you must inform the front desk upon arrival. These cases will require prior authorization be on file before appointment date/time, please contact the scheduling department at 732-575-1100 option 2 prior to your appointment.

If you have a someone accompany you to your appointment, we ask they remain in the waiting room until the provider is ready to see you. At that time, if you choose, your companion may join you.

Prior to leaving the office, we ask that patients stop to schedule their follow-up appointment, if required.

Our providers are on call 24 hours a day / 7 days a week. If you need to reach a provider after hours or on weekends, call the office and speak to the answering service. Your call will be returned by the physician on-call. Remember to keep your phone line open so you can receive the call, (you may not recognize the number calling, it may be blocked or marked private). If your call is not returned in a reasonable amount of time, please call again.

Our offices are handicapped accessible and we have wheelchairs for use in the office.

You will be contacted by the staff several days prior to your scheduled appointment. They will verify demographic, insurance and pharmacy information. Along with gather information about previous testing, hospitalizations and/or information specific to sleep patients.

If you have any questions or concerns, please do not hesitate to speak to our staff.

Shore Pulmonary Insurance Company & Financial Policy

In the last several years, the number of different health insurance plans have increased exponentially. Even within one company there ay be several new plans with varying benefits and requirements. There is no way that we can possibly keep up-to-date with each company and all their plans.

Some insurance plans:

- Require that a specific facility be used for X-rays, ultrasounds, other radiology and bloodwork.
- Require a minimum number of days between radiologic testing, i.e., 366 days.
- Require prior-authorizations, some do not.
- Require the PATIENT to notify them of hospital admissions or trips to the emergency room, other require specific information regarding hospitalizations.
- Require referrals, while others do not. If required, referrals should be obtained 72 business hours prior to your appointment date. We will not be able to see you without a referral.

It is the Patient's responsibility to know:

- Your financial obligations, co-pays, co-insurance and deductibles.
- Whether or not this office is participating with your insurance plan.
- Whether or not you require a referral and if you need a new referral.
- Advise this office of your plan's requirements in advance, each and every time we provide service. We will do our best to comply with any reasonable requirements that your particular plan may have.

Please understand that if we have not been advised in advance of your plans requirements or conditions and we provide a service, use a laboratory or facility that is outside your plan, you will be responsible for the appropriate fees.

In addition, there are times when we may not be able to obtain a consultant, laboratory or facility that participates with your plan. It will be up to you to work this out with your insurance company.

These are not Shore Pulmonary rules; they are your insurance company's regulations and unless you follow them carefully the insurance company may decline all or part of your claim. Your insurance company should have provided you with a phone number for you to use if you have any questions about your coverage. Please be sure to keep this page with your insurance paper for future reference.

If we do not participate with your insurance company/plan, we will gladly provide you with an itemized receipt for your full payment.

For missed appointments or any appointment cancelled without at least 24 hours in advance of the visit, we reserve the right to charge for reserving a slot for you.

Past due balances must be paid in full, BEFORE future appointments can be made.

You will be responsible for the fee of any collection agency and any and all costs/expenses incurred (including attorney fees) in the collection of your owed balance.

Our office accepts Cash, Checks and most major Credit Cards.

I have reviewed and understand the Shore Pulmonary Welcome Letter, Office Information Sheet, and the Insurance Company and Financial Policy, I agree to accept financial responsibility for the above.

Patient Signature	Date
Responsible Party Signature (if not patient)	Date

Shore Pulmonary
Acknowledgement of Notice of Privacy Practices and HIPAA Release of Information

Shore Pulmonary, PA reserves the right to modify the privacy practices outlined in our Notice of Privacy Practices. We, along with other Health Care Providers in New Jersey participate in Jersey Health Connect, a health information exchange (HIE) which allows patient information to be shared electronically through a secured network that is accessible to all providers treating you. We may disclose your medical information to Jersey Health Connect.

I understand or have reviewed/read a copy of the Notice of Privacy Practices for Shore Pulmonary. PA (available at the front desk),

Print Patient Name

Patient Signature / Date

Responsible Party Signature (if not patient)

Relationship to Patient

List members of family or significant others that may receive my medical information concerning my condition and care:

Full Name	DOB or SSN	Relationship

SHORE PULMONARY, P.A. **Patient Information Sheet**

PLEASE PRINT CLEARLY

Last Name		**First Name**		**Middle Name**
Maiden Name	**Age**	**Date of Birth**	**Sex** Other	**SSN**
Other **Marital Status**		**RACE:** Other:		

Street Address	**City/State/Zip**	
Home Phone	**Cell Phone**	**Work Phone**
Home Phone **Preferred Contact Method**	**Email Address**	

Employer Name / Address

Emergency Contact	**Phone**	**Relationship**

Pharmacy Name	**Pharmacy Address (Street Name / City / State)**	
Pharmacy Phone	**Pharmacy Fax**	

Referring Physician	**Primary Care Physician (if different)**	**Phone**

Primary Insurance Company	**Policy Number**	**Group Number**
Policy Holder Name (if not patient)	**Policy Holder Address / City / State / Zip (if different)**	

Secondary Insurance Company	**Policy Number**	**Group Number**
Policy Holder (if not patient)	**Policy Holder Address / City / State / Zip (if different)**	

☐ ***If Patient is a Medicare Recipient:***

I authorize any holder of medical or other information about me to be released to the Social Security Administration and the Centers for Medicare and Medicaid Services (CMS) of their intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize this office to furnish my insurance carriers with anu information relevant to my claim, and to make direct payment when accepted.

☐ ***If Patient is Covered by Health Insurance:***

I request all payments to be made to this provider directly for covered services. I agree to pau any amount the insurance company did not or will not pay.

☐ ***Medigap Waiver:***

I request that payment of authorized Medigap benefits be made to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to my Medigap insurance any information needed to determine these benefits payable for related services.

Medigap Insurance	**HIC#**
Patient Signature	**Date**
Responsible Party Signature (if not patient)	**Date**

SHORE PULMONARY, P.A. **Patient History Form**

PLEASE PRINT CLEARLY

Last Name		**First Name**		**Middle Name**
Birth Place	**Age**	**Date of Birth**	**Sex** Other	**SSN**
Primary Care / Family Doctor Name and Phone		**Occupation**		**Previous Occupation**
Date of Last Physical		**With Whom**		
Reason for Today's Visit				

Please answer for yourself and if yes, answer for parents, and indicate if any other family member(s) have or have a history of:

PERSONAL / FAMILY HISTORY

	Myself N	Myself Y	Mother N	Mother Y	Father N	Father Y	Other--Who?
Cancer, including Leukemia?	☐	☐	☐	☐	☐	☐	
Tuberculosis?	☐	☐	☐	☐	☐	☐	
Diabetes?	☐	☐	☐	☐	☐	☐	
Heart Disease?	☐	☐	☐	☐	☐	☐	
High blood pressure?	☐	☐	☐	☐	☐	☐	
Stroke?	☐	☐	☐	☐	☐	☐	
Sleep Apnea?	☐	☐	☐	☐	☐	☐	
Asthma?	☐	☐	☐	☐	☐	☐	
Allergies?	☐	☐	☐	☐	☐	☐	
Liver disease?	☐	☐	☐	☐	☐	☐	
Emphysema?	☐	☐	☐	☐	☐	☐	
Stomach or duodenal ulcer?	☐	☐	☐	☐	☐	☐	
Glaucoma?	☐	☐	☐	☐	☐	☐	
COPD?	☐	☐	☐	☐	☐	☐	
Bleeding disorders? (Including clotting, embolism, thrombosis)	☐	☐	☐	☐	☐	☐	

SOCIAL HISTORY

	N	Y
Do you currently smoke?	☐	☐
If yes, how much?		
Have you ever smoked?	☐	☐
When did you quit?		
Exposed to 2nd hand smoke?	☐	☐
How often?		
Currently / how long ago?		
Do you drink alcohol?	☐	☐
If yes, how much?		
How often?		
Do you have sleep issues?	☐	☐
Snoring?	☐	☐
Daytime sleepiness?	☐	☐
Fatigue?	☐	☐
Falling asleep driving?	☐	☐

IMMUNIZATIONS

	N	Y	Date MM/DD/YY
FLU	☐	☐	
Pneumonia	☐	☐	
Tetanus	☐	☐	
COVID-19	☐	☐	

Vaccine 1 Date **Vaccine 2 Date** **Manufacturer**

Booster 1 Date **Booster 2 Date** **Booster 3 Date**

Tuberculosis ☐ ☐ Have you ever had a positive reaction to a skin test? N☐ Y☐

If so: **When** **Type of Treatment**

ALLERGIES

	N	Y
Are you allergic to any medication? (List medications)	☐	☐
Are you allergic to any food? (List foods)	☐	☐

Name _____ Date of Birth _____

SURGICAL HISTORY

	N	Y	Date mm/dd/yy		N	Y	Date mm/dd/yy
Tonsils / Sinus	☐	☐	_____	Thyroid / Neck	☐	☐	_____
Appendix	☐	☐	_____	Lungs	☐	☐	_____
Gall bladder	☐	☐	_____	Breast	☐	☐	_____
Stomach	☐	☐	_____	Heart	☐	☐	_____
Colon / Bowel	☐	☐	_____	Bypass / Pacemaker	☐	☐	_____
Orthopedic	☐	☐	_____	Other:	☐	☐	_____

DIAGNOSED DIFFICULTIES (Do you Currently have or have you previously had History of any of the following?)

Epilepsy / Convulsions	No History	Rheumatic Fever	No History
Stroke	No History	Angina	No History
Glaucoma	No History	Cirrhosis of the Liver	No History
Asthma	No History	Digestive Disease	No History
Hay Fever	No History	Anemia	No History
Emphysema	No History	Diabetes	No History
Tuberculosis	No History	Thyroid Disease	No History
Abnormal Chest x-ray	No History	Hypothyroid	No History
Heart Disease	No History	Hyperthyroid	No History
Arrhythmia	No History	Phlebitis Embolism	No History
Sleep Apnea	No History	Cholesterol Disorder	No History
Varicose Veins	No History	High Blood Pressure	No History
Ear Infection / Sinus Issues	No History	Stomach / Duodenal	No History
Chronic Bronchitis	No History	Depression / Anxiety	No History

SYSTEM REVIEW

	N	Y		N	Y
Fever	☐	☐	Night Sweats	☐	☐
Aches / Pains	☐	☐	Swollen Ankles	☐	☐
Swollen Glands	☐	☐	Poor Appetite	☐	☐
Chills	☐	☐	Indigestion / Heartburn	☐	☐
General Weakness	☐	☐	Difficulty Swallowing	☐	☐
Ear Pain	☐	☐	Nausea and / or Vomiting	☐	☐
Sinus Pain / Trouble	☐	☐	Abdominal Pain and / or Cramps	☐	☐
Persistent Hoarseness	☐	☐	Change in Bowel Habits	☐	☐
Severe Headache	☐	☐	Breast Lump(s)	☐	☐
Lumps in Neck	☐	☐	Discharge from Nipple	☐	☐
Shortness of Breath	☐	☐	Snoring	☐	☐
Chest Pain and / or Pressure	☐	☐	Daytime Somnolence	☐	☐
Frequent Cough	☐	☐	Wheezing	☐	☐
Coughing up Blood	☐	☐	Poor Exercise / Unusual Heartbeat	☐	☐

DO NOT WRITE BELOW LINE

SHORE PULMONARY USE ONLY

☐ I discussed with the patient the importance of follow-up for all non-pulmonary issues with PCP or an appropriate specialist.

Provider Signature _____ Date _____

Paul Friedman, M.D.
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Gustavo E. de la Luz, M.D.
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Ghadier Al Saoudi, M.D.
Noor Salam, M.D.
Matthew Frank, M.D.

Patient Name | Date

Age | Date of Birth | Sex: Other

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0-Would never doze
1-Slight chance of dozing
2-Moderate chance of dozing
3-High chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	0 Would Never Doze
Watching TV	0 Would Never Doze
Sitting, inactive in a public place (i.e., theater or meeting)	0 Would Never Doze
As a passenger in a car for an hour without a break	0 Would Never Doze
Lying down to rest in the afternoon when circumstances permit	0 Would Never Doze
Sitting and talking to someone	0 Would Never Doze
In a car, while stopped for a few minutes in traffic	0 Would Never Doze

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www.ShorePulmonary.com

SHORE PULMONARY, P.A. **Current Medication List**

PLEASE PRINT CLEARLY

Patient Name	Date of Birth	Today's Date

Please list all your CURRENT medications

Medication	Dosage	Frequency	Start Date	Adverse Reaction	Physician Name
Example: Aspirin	81 mg	Twice a day	01/01/2010	Hives	Dr Jones

List any allergies (food, medication or other; i.e., mushrooms, penicillin, latex):

_____

SAVE Click to Save this file and/or complete it later.

PRINT Click to Print this form at home, (filled out on the computer) and bring it with you,

WEBSITE Click to return to the website to print the full paper form to hand fill out and bring with you.

You can also print this form in our office by: Saving the file, attaching it to an email and sending it to: ShorePulmonaryForms@gmail.com

You can also attach copies of insurance card(s) (front and back) and vaccination cards. This is fully HIPAA compliant.

Or, you may fax the forms to us at 732-575-1107 ATTN: NP Forms

If you are a NEW SLEEP patient, please fill out the following 2 pages, otherwise you are finished.

Shore Pulmonary

Sleep Disorder Questionnaire

Patient Name _____ Date of Birth _____ Today's Date _____

1. Why are you seeking treatment at this time?

   _____

2. Is there any aspect of your sleep environment that seems to contribute to your sleep problems, if yes, explain:

   _____

3. What is your neck size? _____
4. What is your usual bedtime (time you get into bed)? _____
5. What is your usual rise time (the time you get out of bed)? _____
6. Does your bedtime and rise time fluctuate from day to day? _____
7. Do you change your bedtime and rise time on the weekends or on days that you do not work? ..... ☐ Yes ☐ No

   If yes, what is your usual bedtime on weekends or non-work days? _____

   What is your usual rise time on weekends or non-work days? _____
8. How long does it usually take you to fall asleep after you get into bed? _____
9. How many times to you usually awaken during the sleep period? _____
10. What is the average duration of your awakenings? _____
11. On average, how long would you say you are actually asleep each night? _____
12. Do you have a regular nightly routine you follow every night before getting into bed, if yes, explain:

    _____

13. Do you read, watch tv or engage in other activities while in bed before sleep onset, if yes, explain: ..... ☐ Yes ☐ No

    _____

14. Do you usually feel sluggish, sleepy or fatigued upon awakening in the morning? ..... ☐ Yes ☐ No
15. Do you usually feel fatigued throughout the day? ..... ☐ Yes ☐ No
16. Do you have difficulty functioning at work due to fatigue? ..... ☐ Yes ☐ No
17. Do you tend to fall asleep at inappropriate times? ..... ☐ Yes ☐ No

Shore Pulmonary

Sleep Disorder Questionnaire Page 2

Patient Name _____ Date of Birth _____ Today's Date _____

		Yes	No
18.	Have you had a motor vehicle accident due to sleepiness or fatigue?	☐	☐
19.	Do you usually nap during the day?	☐	☐
20.	Do you usually have difficulty falling asleep at the beginning of the sleep period?	☐	☐
21.	Do you wake up too early and find that you can't return to sleep?	☐	☐
22.	Do you snore?	☐	☐
23.	Have you awakened yourself or someone else with snoring sounds?	☐	☐
24.	Has anyone ever told you, you seem to have difficulty breathing or that you stop breathing during sleep?	☐	☐
25.	Do you ever awaken with the sensation of shortness of breath?	☐	☐
26.	Do you ever awaken gasping, choking or "gulping for air"?	☐	☐
27.	Do you often awaken with a dry mouth or sore throat?	☐	☐
28.	Do you ever awaken with headaches?	☐	☐
29.	Have you had surgery for snoring or sleep apnea?	☐	☐
30.	Have you ever experienced "sleep attacks" (sudden irresistible urge to sleep)?	☐	☐
31.	Upon falling asleep or waking up have you ever had the experience of being unable to move move your arms or legs, even if you try?	☐	☐
32.	Have you ever done things during the day without having awareness of your actions?	☐	☐
33.	Have you ever experienced sudden muscle weakness while awake (in mild conditions, this could be experienced as a weak grip or leg or arm weakness)? In severe conditions, one's legs might buckle and the person might fall to the floor?	☐	☐
34.	Do you experience painful or unusual sensations in your legs while at rest, especially in the evening?	☐	☐
35	Do you ever experience "twitching" or "jerking" of your feet or legs while asleep?	☐	☐
36.	Are you a shift worker (evenings, nights or rotating shifts)?	☐	☐
37.	Do you suffer from jet lag?	☐	☐
38.	Do you find that you typically fall asleep earlier than desired and awaken earlier than desired?	☐	☐
39.	Do you find that you typically fall asleep later than desired and awaken later than desired?	☐	☐
40.	Have you now, or have you ever in the past, received treatment for high blood pressure?	☐	☐
41.	Have you been told that you have an irregular heartbeat (cardiac arrhythmia)?	☐	☐
42.	Have you ever suffered a stroke?	☐	☐
43.	Have you ever suffered a heart attack?	☐	☐

PLEASE RETURN TO THE BOTTOM OF PAGE 9