

MARC J. KORNFELD, MD., P.C.  
PHYSICAL MEDICINE & REHABILITATION

Method of Payment:  
\_\_\_cash \_\_\_visa/MC  
\_\_\_check \_\_\_other

Please contact our office if your pain has been present less than 6 weeks\*

PATIENT REGISTRATION

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Sex: \_\_\_ Age: \_\_\_ (R) \_\_\_ or (L) \_\_\_ Handed Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Have you ever been treated by us before? (Yes) (No) When? \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Primary Insurance:

Insured's Name: \_\_\_\_\_ Insurance Co. Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance:

Insured's Name: \_\_\_\_\_ Insurance Co. Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Workers' Compensation Only:

Date of Injury: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Rehab Counselor's Name (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby authorize payment of insurance benefits directly to Dr. Marc J. Kornfeld, M.D., P.C. where services were rendered. I further authorize the release of any medical information to facilitate reimbursement of the service(s) rendered. I understand that I will be responsible for the payment of all deductibles, co-payments and any other charges not covered by my insurance plan.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## QUESTIONNAIRE

### MEDICAL HISTORY UNRELATED TO PAIN PROBLEM

List any health problems that you have **not** related to your current pain problem (cancer, diabetes, heart disease, etc.)

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List any family medical history problems: \_\_\_\_\_

Please list any surgeries you have had **not** related to your pain problem: \_\_\_\_\_

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Please list any allergies: \_\_\_\_\_

### HISTORY OF CURRENT PAIN PROBLEM:

Date of injury/accident or when the symptoms first began: \_\_\_\_\_

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Work related (please circle) **YES** or **NO**

Describe how your pain problem began (fall, lifting, pulling, woke up with the pain): \_\_\_\_\_

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Please describe how your pain feels right now (sharp, dull, burning): \_\_\_\_\_

### Pain level right now (place a "x" on the line)

No pain	1	3	5	7	9	worst pain ever				
0	minimal pain	2	mild pain	4	moderate pain	6	severe pain	8	unbearable pain	10

### Pain level most of the time (place a "x" on the line)

No pain	1	3	5	7	9	worst pain ever				
0	minimal pain	2	mild pain	4	moderate pain	6	severe pain	8	unbearable pain	10

### Pain level while taking medications (place a "x" on the line)

No pain	1	3	5	7	9	worst pain ever				
0	minimal pain	2	mild pain	4	moderate pain	6	severe pain	8	unbearable pain	10

## HISTORY OF EVALUATION

**List all the physicians you have seen related to your pain problem:**

Doctor's Name	Type of Doctor	Phone/Fax Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Please list any surgeries you have had related to your pain problem:**

Surgery	Date of Surgery	Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Medications related to your current pain: (include sleep, anxiety, and depression meds)**

Names	Dose	Times per day	Doctor Prescribing
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**List any other medications you are taking for non-related problem (include OTC): \_\_\_\_\_**

\_\_\_\_\_