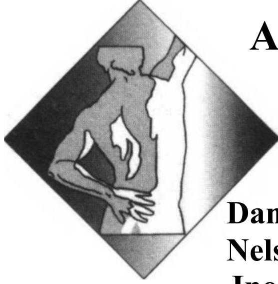


Advantage Physical Medicine and Rehabilitation, LLC

60 Dunning Road, Middletown, New York 10940
Telephone: (845)344-4477 Fax: (845)344-6072

Daniel Perri, M.D.[1,2]
Nelson Wong, M.D.[1]
Inocencia Carrano, M.D. [1,3]

[1] *Board Certified, Physical Medicine & Rehabilitation*
[2] *Board Certified, Pain Medicine*
[3] *Board Certified, Spinal Cord Injury*

OFFICE REGISTRATION

Name: ________________________ MI: ____ Last Name: ____________________

Mailing Address: ____

Address 2: ____

City: ________________________ State: _______ Zip: ______________

Home Phone: ________________ Work Phone: ______________ ext.______ Cell Phone: _________

Email Address: ____

Date of Birth: ____/____/____ Social Security #: ________________ Circle: Male or Female

Primary Care Dr.: ________________________ Referring Dr.: ________________________

Primary Name & Address: ____

Pharmacy Phone #: ____________________________

Race (check one):
( ) White ( ) American Indian/Alaska Native ( ) Asian ( ) Other
( ) Black/African American ( ) Native Hawaiian/Other Pacific Islander ( ) Patient Declined/Unknown

Ethnicity:
( ) Spanish/Hispanic Primary Language: Country:
( ) Not of Hispanic Origin Secondary Language: Country:

Insurance Information Below:
Primary Insurance Company: ____

Address: ____

Policy Holders Name: ____________________ DOB: ______________ SSN: _____________

ID #: ____________________________ Relationship to Insured: Self, Spouse, Child, Other

Employer of policy holder: ____

Secondary Coverage (If Applicable):
Insurance Company Name: ____________________________ ID #: ____________________

Address: ____

Policy Holders Name: ____________________ DOB: ______________ SSN: _____________

Name: **Date:**

SYMPTOM CHECKLIST

List Medical History (e.g. High Blood Pressure, Cancer, etc.)

List Surgeries:

Medications (with dosages):

Drug Allergies:

Family History (medical problems in your immediate family):

Are you presently working? YES NO

What is your occupation? ____

If retired, what was your prior occupation? ______________________________

Tobacco use: NO YES If YES, how much?

Alcohol use: NO YES If YES, how much?

Other drug use: NO YES If YES, what drug and how much?

Symptoms	**Please Circle**
Fever or night sweats	NO YES
Chest Pain	NO YES
Loss of bowel control	NO YES
Loss of bladder control	NO YES
Inflammatory Arthritis	NO YES
Skin rashes	NO YES
Weakness	NO YES
Depressed mood	NO YES
Difficulty Sleeping	NO YES
Diabetes Thyroid disease	NO YES

Workers Compensation/No Fault Information

Name: ___________________________________

Is this an auto related injury? YES NO

Is this a work related injury? YES NO

Date of accident: ____/____/____

Are you currently working? YES NO

Job Title: _____________________________

Job Description: ____

WC/No Fault Carrier: ____

Claim #: ______________________________________ Case #: _________________________

Claim Address: ____

City: _____________________________ State: ______ Zip: ______________

Adjustor Information:

Contact Person: ____

Tel #: ______________________________ ext. __________ Fax #: _______________________

Employer Information:

Name of Employer: ____

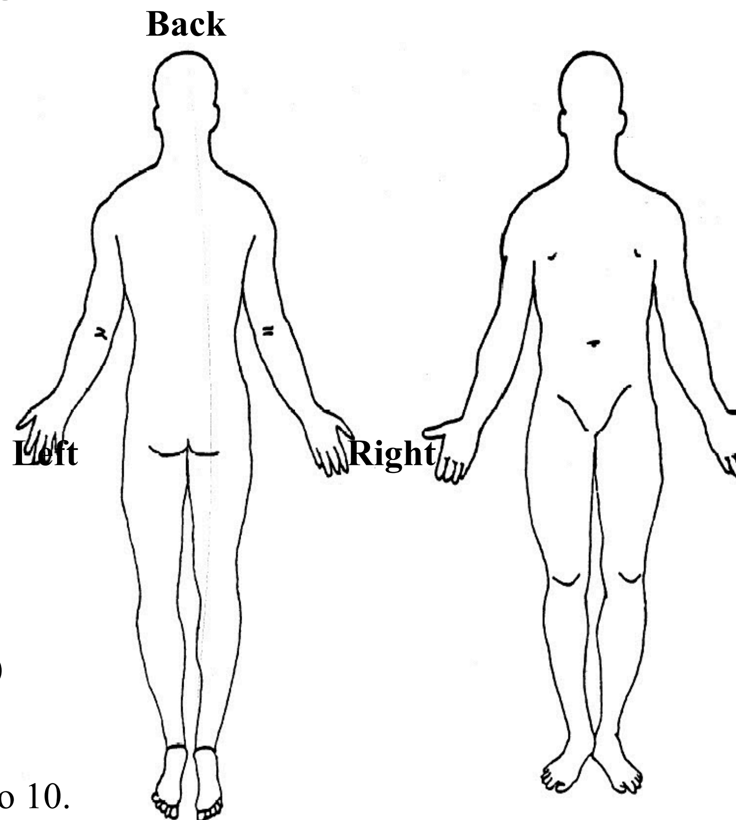
Address: ____

City: ________________________ State: _________ Zip: _________________

Name: Date:

Pain Diagram

Please mark on the diagrams:



Front

Pain = X
Numbness/tingling = O
Both = place O with an X through it

1. Was there an injury?
   If so, what was the date?

2. How long have you had your pain?
   Left

3. Please describe the quality of your pain.
   (Sharp, dull, stabbing, ache, throb or other)

4. Please rate your current pain level from 0 to 10.

5. Does your pain radiate or travel?

6. Is your pain constant or does it come and go?

7. What makes the pain worse? (Bending, lifting, sitting, standing, walking or other)

8. What makes the pain better? (Medications, rest, therapy, ice, heat, or other)

9. Do you have any numbness or tingling?