**JOHN F. COOK, JR., M.D.**
A MEDICAL CORPORATION

SURGERY OF THE HAND AND UPPER EXTREMITY
ORTHOPAEDIC SURGERY

OFFICE (949) 644-9000
FAX (949) 644-4378

1441 AVOCADO AVENUE, SUITE 807
NEWPORT BEACH, CALIFORNIA 92660

Welcome to our practice. I am pleased that you have chosen me and my staff to manage your orthopedic health needs.

As a Board Certified Hand Surgeon and Board Certified Orthopedic Surgeon, it is my goal to provide the highest quality medical and surgical services to each individual in my care.

My staff is trained to coordinate your appointment scheduling, manage your financial account responsibilities, and to provide a professional, friendly and caring atmosphere.

So that we may better serve you, please take a few moments to fill out the enclosed forms.

Thank you and I look forward to meeting you.

Sincerely,

John F. Cook, Jr., M.D.
JFC/rs

# PATIENT INFORMATION & REGISTRATION FORM

JOHN F. COOK, JR., M.D.
A Medical Corporation

**PLEASE PRINT**

**PATIENT'S LEGAL NAME:** **TODAYS DATE:**_____

_____ AGE:_____DATE OF BIRTH:___/____/____
LAST FIRST MI

ADDRESS:_____
STREET (NO PO BOX) CITY STATE ZIP

PHONE: (  )_____ (  )_____ (  )_____ SEX: M ☐ F ☐
HOME WORK CELL

EMAIL:_____ DRIVERS LIC #:_____ SS#:_____

EMPLOYER:_____OCCUPATION:_____

SPOUSE'S NAME:_____ SS#:_____

EMPLOYER:_____

**IF UNDER 18 YEARDS OLD, RESPONSIBLE PARTY:** RELATIONSHIP:_____

_____ AGE:_____DATE OF BIRTH:___/____/____
LAST FIRST MI

ADDRESS:_____
STREET CITY STATE ZIP

PHONE: (  )_____ (  )_____ (  )_____ SEX: M ☐ F ☐
HOME WORK CELL

EMAIL:_____ DRIVERS LIC #:_____ SS#:_____

**INSURANCE INFORMATION:** (PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD)

NAME OF INSURANCE COMPANY:_____ ID#:_____GROUP#_____

SECONDARY INSURANCE COMPANY:_____ ID#:_____GROUP#_____

CO-PAYMENT AMOUNT $_____ DEDUCTIBLE AMOUNT $_____DO YOU HAVE MEDICARE?_____

NAME OF SUBSCRIBER _____ DATE OF BIRTH _____ RELATIONSHIP _____

IN CASE OF EMERGENCY NOTIFY: _____
NAME RELATIONSHIP PHONE #

IF INJURY, DATE OF ACCIDENT____/____/____TIME:_____ WORK RELATED?_____

HOW DID IT HAPPEN?_____

DO YOU HAVE AN ATTORNEY?_____ATTORNEY NAME:_____

REFERRED BY: DOCTOR, HOSPITAL, FAMILY, FRIEND, OTHER_____

**SIGNATURE:**_____

# JOHN F. COOK, JR., M.D.

A MEDICAL CORPORATION

TELEPHONE
(949)644-9000

1441 AVOCADO AVENUE, SUITE 807
NEWPORT BEACH, CALIFORNIA 92660

**Date**_____

**Name of Insurance Co.** _____ **Name of Insured/Patient**_____

I hereby authorize John F. Cook, Jr., M.D. to release my authorized insurance company or its representative any information including the diagnosis and the records of any treatments or examination rendered to me during the period of any medical or surgical care.

My insurance company or its representative is also authorized to release directly to this doctor or any information regarding claims submitted on my behalf or any information required by the doctor to submit each claim.

I authorize that the above listed insurance company to pay directly to John F. Cook, Jr., M.D. the amount due and payable on claims for basic medical, major medical, and/or surgical treatment or services by reason of such treatment or services rendered.

**Co-Payments and Co-Insurance:** We ask that you pay your co-pay amount at the time of your visit. Many PPO patients may pay a percentage of their insurance carrier's allowed amount as a co-insurance. We ask that you pay your co-insurance amount at the time of your visit also.

**Deductibles:** We ask that you pay your deductible amount at the time of your visit.

**Ineligible or Denied Services:** If any service is considered "ineligible or services are denied" under your health plan you will be responsible for payment of all services rendered by Dr. Cook.

**Self-Pay:** We ask that you pay for all services at time of your visit.

**Signature of Insured/Patient:**_____

**JOHN F. COOK, JR., M.D.**
**A Medical Corporation**

## PAST AND PRESENT MEDICAL HISTORY

**ALLERGIES:** Are you allergic and/or had a reaction to any medications, anesthesia, or substances like nickel or latex? Please name the substance and the type of reaction:

_____

_____

**MEDICATIONS:** List medications you take daily (include name, dose and frequency):_____

_____

_____

List medications you take occasionally:_____

Supplements/Herbal Remedies:_____

**PREVIOUS SURGERIES:** Begin by listing most recent:

| YEAR | SURGERY NAME | YEAR | SURGERY NAME |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**FAMILY** members with any medical problems (diabetes, high blood pressure, cancer, fibromyalgia, alcohol or drug addiction or other):_____

_____

If disabled, cause of disability:_____

Do any family members have the same problem you have (who and what problems):

_____

**SOCIAL:**

Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed

Number of children? _____ ages_____ Do they live with you?_____

Education completed: _____grade _____high school_____college_____post graduate

Military Service?_____Branch_____Years of service_____Service disability?_____

Do you smoke?_____ Cigarettes/Cigars _____ How many per day?_____

Do you Vape? _____ How many times per day? _____ Home many times per week? _____

Do you consume Marijuana/Cannabis? _____ In what form? _____How often? _____

Alcohol?_____What kind, and how much per day?_____

Drugs?_____What kind, and how much per day?_____

_____ _____ _____

Sign Name Print Name Date

# JOHN F. COOK, JR., M.D. - PAST MEDICAL HISTORY

**Check the first box if you have this NOW. Check the second box if you had this in the PAST.**

| | NOW | PAST |
|---|---|---|
| Diabetes | | |
| High Blood Pressure | | |
| Stroke | | |
| Angina | | |
| Chest Pain | | |
| Heart Attack | | |
| Heart Trouble | | |
| Heart Murmur | | |
| Mitral valve prolapse | | |
| Bladder trouble | | |
| Kidney trouble | | |
| Kidney stones | | |
| Cancer | | |
| Hepatitis | | |
| Jaundice | | |
| Thyroid disorder | | |
| Tuberculosis | | |
| Pneumonia | | |
| Emphysema | | |
| Asthma | | |
| Respiratory illness | | |
| Epilepsy (seizures) | | |
| Polio | | |
| Neurological disease | | |
| Tension headache | | |
| Migraine headache | | |
| Mental or nervous disorder | | |
| Ulcer | | |
| Pancreatitis | | |
| Liver trouble | | |
| Gallbladder trouble | | |
| Colitis | | |
| Hernia | | |
| Anemia | | |
| Bleeding trouble | | |
| Phlebitis (blood clots) | | |
| Psoriasis | | |
| Eczema | | |
| Other skin diseases | | |
| Osteoarthritis | | |
| Gout | | |
| Sciatica | | |
| Back problems | | |
| Alcoholism | | |
| Drug addiction | | |
| IV drug use | | |
| Immune system problems | | |
| Rheumatoid arthritis | | |
| Lupus | | |
| Chronic fatigue | | |
| Fibromyalgia | | |
| Epstein-Barr virus | | |
| Irritable bowel | | |
| Hypoglycemia | | |
| Depression | | |
| Tropical disease | | |
| Genital or gynecological conditions | | |
| Multiple sexual partners | | |
| Previous blood transfusions | | |

**I have not had any of the above:** ☐ **Are you pregnant?**_____

_____ _____ _____

sign name print name date

# JOHN F. COOK, JR., M.D. - REVIEW OF SYSTEMS

Check the first box if you have this **NOW.** Check the second box if you had this in the **PAST**

| CONSTITUTIONAL: | NOW | PAST |
|---|---|---|
| Fatigue | | |
| Feeling ill | | |
| Fever | | |
| Loss of appetite | | |
| Weight gain | | |
| Weight loss | | |

| EYES: | | |
|---|---|---|
| Blurred vision | | |
| Double vision | | |
| Eye pain | | |
| Eye trauma | | |
| Glasses/contacts | | |

| EARS: | | |
|---|---|---|
| Decreased hearing | | |
| Noises in ears | | |

| NOSE AND THROAT: | | |
|---|---|---|
| Difficulty swallowing | | |
| Frequent sore throat | | |
| Hoarseness | | |
| Nose bleeds | | |
| Stuffy nose | | |

| PULMONARY: | | |
|---|---|---|
| Asthma | | |
| Coughing up blood | | |
| Excessive cough | | |
| Pain with breathing | | |
| Shortness of breath | | |
| Wheezing | | |

| CARDIOVASCULAR: | | |
|---|---|---|
| Abnormal or fast heartbeat | | |
| Bruise easily | | |
| Chest pain | | |
| Cold sensitivity in fingers/toes | | |
| Swelling | | |

| GASTROINTESTINAL: | | |
|---|---|---|
| Heartburn | | |
| Bloody or tarry stools | | |
| Frequent abdominal pain | | |
| Frequent constipation | | |
| Frequent diarrhea | | |
| Hemorrhoids | | |
| Loss of bowel control | | |
| Vomiting | | |

| MUSCLOSKELETAL: | | |
|---|---|---|
| Back pain | | |
| Deformity | | |
| Joint pain | | |
| Muscle aches or spasms | | |
| Neck pain | | |
| Stiffness | | |
| Swelling | | |

| FEMALE: | NOW | PAST |
|---|---|---|
| Breast pain | | |
| Excessive menstrual bleeding | | |
| Infection | | |
| Painful intercourse | | |
| Painful periods | | |
| Tumors of uterus or ovary | | |

| MALE: | | |
|---|---|---|
| Abnormality or testicles/penis | | |
| Erectile difficulty | | |
| Infection | | |
| Pain during sex | | |

| URINARY: | | |
|---|---|---|
| Blood in urine | | |
| Difficulty urinating | | |
| Frequent urination | | |
| Loss of urinary control | | |
| Painful urination | | |
| Urinary tract infection | | |

| ENDOCRINE: | | |
|---|---|---|
| Diabetes | | |
| Swollen glands | | |
| Thyroid problems | | |

| SKIN: | | |
|---|---|---|
| Discoloration | | |
| Eczema | | |
| Itchiness | | |
| Psoriasis | | |
| Rash | | |

| NEUROLOGICAL: | | |
|---|---|---|
| Dizziness | | |
| Loss of balance | | |
| Numbness of arms | | |
| Numbness of legs | | |
| Shaking or twitching of limbs | | |
| Weakness of arms | | |
| Weakness of legs | | |

| EMOTIONAL: | | |
|---|---|---|
| Anxiety-nervousness | | |
| Claustrophobia | | |
| Panic attacks | | |
| Frequent nightmares | | |
| Mood changes | | |
| Depression | | |
| Feelings of worthlessness | | |
| Irritability | | |
| Pressure at work | | |
| Problems at home | | |
| Problems at work | | |
| Problems at home as child | | |
| Difficult relationships | | |
| Abusive relationships | | |
| Abuse: physical, sexual, emotional | | |
| Hallucinations | | |
| Psychiatric problems | | |

**ENVIRONMENTAL ALLERGIES:** ☐

I HAVE NOT HAD ANY OF THE ABOVE ☐

Sign Name _____ Print Name _____ Date _____

# JOHN F. COOK, JR., M.D. - SUPPLEMENTS CHECK LIST

Check the box if you take this **NOW**

| **Common Supplements:** | |
|---|---|
| | |
| Cranberry | |
| Echinacea | |
| Feverfew | |
| Garlic | |
| Ginkgo | |
| Ginseng | |
| Milk thistle | |
| Saw palmetto | |
| Soy | |
| St. John's wort | |
| Valerian | |
| | |
| Glucosamine | |
| Chondroitin sulfate | |
| SAM-e | |
| ASU's | |
| Black cohosh | |
| Boswellia | |
| Bromelain | |
| Cat's claw | |
| Flavocoxid | |
| Thunder god vine | |
| Turmeric | |
| | |
| Other: | |
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| | |

**I do not take any of the above or any other supplements:** ☐

sign name _____ print name _____ date _____

# OPEN PAYMENTS DATABASE NOTIFICATION

## AB 1278

Beginning January 1, 2023 California AB 1278 requires physicians to provide notice about the federal Open Payments Program to their patients at their initial office visit. This notice is to be signed and dated by the patient. A copy of the written notice must be provided to the patient (or their representative) and included in the patient's records.

**"The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at openpaymentsdata.cms.gov."**

_____ _____

Patient Signature Date