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, CA 92660-7788

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

During this current pandemic, your safety and the safety of our team is our highest priority. To this end, we are using the following universal precautions:

1. We ask you to please wear a facemask or face guard during your time in our office.

2. Upon arrival, your temperature will be taken and your medical history, current symptoms and travel history will be confirmed.

3. Patient appointments are coordinated to eliminate patient overlap as much as possible.

4. All surfaces are routinely disinfected before and after patient contact (door handles, countertops, pens, etc.).

5. My team and I will be wearing facemasks, gloves, and eye shields.

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 team 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 fill out the enclosed forms.

Thank you and I look forward to meeting you.

Sincerely,

John F Cook, Jr, MD

John F. Cook, Jr., M.D.

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#:_____

EMPLOYER:_____OCCUPATION:_____

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?_____

IN CASE OF EMERGENCY NOTIFY: _____

NAME RELATIONSHIP PHONE #

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

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, or 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

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?_____ How many per day?_____ Vape? _____

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		
Tumor or Cancer		
Hepatitis or Jaundice		
Thyroid disorder		
Tuberculosis		
Pneumonia		
Emphysema		
Asthma		
Respiratory illness		
Epilepsy (seizures)		
Polio		
Neurological disease		
Tension or 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 or 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		
Sex with person of same sex		
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 or loss of balance		
Numbness of arms or legs		
Shaking or twitching of limbs		
Weakness of arms or 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	
Tumeric	
Other:	

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

sign name _____ print name _____ date _____