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

SURGERY OR THE HAND AND UPPER EXTREMITY
ORTHOPAEDIC SURGERY

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

1441 AVOCADO AVENUE, SUITE 802
NEWPORT BEACH, CALIFORNIA 92660

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

As a Board Certified Hand Surgeon and Board Certified Orthopaedic 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.

PLEASE FILL OUT THE NECESSARY INFORMATION BELOW FROM YOUR COMPUTER, SIMPLY HIT THE PRINT BUTTON AFTERWARDS, SIGN AND BRING TO OUR OFFICE TO AVOID LONGER WAIT PROCEDURES.

"Like" us on Facebook and receive
medical updates:
"Dr. John Cook Orthopedic Hand Specialist"

Print Form

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

SURGERY OR THE HAND AND UPPER EXTREMITY
ORTHOPAEDIC SURGERY

TELEPHONE
(949)644-9000

1441 AVOCADO AVENUE, SUITE 802
NEWPORT BEACH, CALIFORNIA 92660

Date_____

Name of Insured_____

I herby 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.

Signature of Insured:_____

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? Please name the medication 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?_____

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	☐	☐
Gall bladder 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

Print Form