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: ____________________________

AGE: _______ DATE OF BIRTH: ______ / ______ / ______

LAST NAME: ____________________ FIRST NAME: ______ 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 YEARS OLD, RESPONSIBLE PARTY: ______________________

RELATIONSHIP: ______________________

AGE: _______ DATE OF BIRTH: ______ / ______ / ______

LAST NAME: ____________________ FIRST NAME: ______ 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: __________________________
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:

<table>
<thead>
<tr>
<th>YEAR</th>
<th>SURGERY NAME</th>
<th>YEAR</th>
<th>SURGERY NAME</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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

I have not had any of the above: ☐

Are you pregnant? ________

sign name ___________________ print name ___________________ date __________
### Constitutional:
- 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

### Musculoskeletal:
- Back pain
- Deformity
- Joint pain
- Muscle aches or spasms
- Neck pain
- Stiffness
- Swelling

### Female:
- Breast pain
- Excessive menstrual bleeding
- Infection
- Painful intercourse
- Painful periods
- Tumors of uterus or ovary

### Male:
- Abnormality of 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**
<table>
<thead>
<tr>
<th>Common Supplements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cranberry</td>
</tr>
<tr>
<td>Echinacea</td>
</tr>
<tr>
<td>Feverfew</td>
</tr>
<tr>
<td>Garlic</td>
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<tr>
<td>Ginkgo</td>
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<tr>
<td>Ginseng</td>
</tr>
<tr>
<td>Milk thistle</td>
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<tr>
<td>Saw palmetto</td>
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<tr>
<td>Soy</td>
</tr>
<tr>
<td>St. John’s wort</td>
</tr>
<tr>
<td>Valerian</td>
</tr>
<tr>
<td>Glucosamine</td>
</tr>
<tr>
<td>Chondroitin sulfate</td>
</tr>
<tr>
<td>SAM-e</td>
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<tr>
<td>ASU’s</td>
</tr>
<tr>
<td>Black cohosh</td>
</tr>
<tr>
<td>Boswellia</td>
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<tr>
<td>Bromelain</td>
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<tr>
<td>Cat’s claw</td>
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<tr>
<td>Flavocoxid</td>
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<tr>
<td>Thunder god vine</td>
</tr>
<tr>
<td>Turmeric</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

**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