

**John A.P. Rimmer, M.D., F.R.C.S.**  
**Diplomate American Board Of Surgery**  
**Breast and General Surgery**

210 Jupiter Lakes Blvd.  
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Jupiter, FL 33458  
(561)748-1242 Phone  
(561)746-1162 Fax

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: FEMALE / MALE SS#: \_\_\_\_\_

MARITAL STATUS: S M W D SPOUSES NAME: \_\_\_\_\_ PHONE#: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

EMERGENCY CONTACT: (If other than spouse)

NAME: \_\_\_\_\_ PHONE#: \_\_\_\_\_ RELATION: \_\_\_\_\_

LOCAL ADDRESS:

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

OUT OF STATE ADDRESS:

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_

REFERRING PHYSICIAN (If different than primary): \_\_\_\_\_ PHONE#: \_\_\_\_\_

**PLEASE READ AND SIGN BELOW**

- Payment for services is expected at the time of visit
- If insurance is filed, I authorize benefits be paid directly to John A.P. Rimmer, MD, PA
- I understand that I am ultimately responsible for balance on account regardless of insurance coverage. By signing this form I agree that if my insurance denies full or partial payment for the services rendered that I will be fully responsible for said charges. This can include denial due to non-covered services, a non participating physician or facility. I understand it is my responsibility to ensure that I am seeking services from a participating Physician or facility
- My failure to pay off outstanding balances on my account may result in collection procedure.
- I authorize John A.P. Rimmer, MD to release any information requested with regard to the processing of my claims
- Failure to give 24 hour notice prior to canceling an appointment may result in a cancellation fee charged to my account
- I also understand that John A.P. Rimmer, MD charges a \$25 bounced check fee

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

HEALTH HISTORY FORM  
John A.P. Rimmer, MD

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

LIST OF CURRENT MEDICATIONS (including Aspirin, Vitamins, and all other over the counter medications):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICATION ALLERGIES:  NONE

\_\_\_\_\_  
\_\_\_\_\_

PREVIOUS SURGERIES: (please include dates)

\_\_\_\_\_  
\_\_\_\_\_

DATE OF LAST PHYSICAL EXAM: \_\_\_\_\_

PERSONAL MEDICAL HISTORY: (please indicate whether you have had any of the following medical problems (√) and give date \_\_\_\_)

If female, could you be pregnant \_\_\_\_\_  Number of Children \_\_\_\_\_  Ages: \_\_\_\_\_  Number of siblings \_\_\_\_\_

Asthma/Lung Disease \_\_\_\_\_

Emphysema \_\_\_\_\_  Difficulty Breathing: Specify \_\_\_\_\_

Breast Disease: Specify \_\_\_\_\_

Cancer: Specify \_\_\_\_\_

Diabetes: controlled by: \_\_\_\_\_  Epilepsy \_\_\_\_\_

Heart Disease: type \_\_\_\_\_  Heart Murmur \_\_\_\_\_  Heart Attack \_\_\_\_\_

Angina \_\_\_\_\_  Chest Tightness: Specify \_\_\_\_\_  Palpitations / Irregular Heart Beat \_\_\_\_\_

High Blood Pressure  Stroke \_\_\_\_\_

Kidney Disease  Stomach or Intestinal Disease: Specify \_\_\_\_\_  Liver Disease \_\_\_\_\_

Pneumonia \_\_\_\_\_  TB \_\_\_\_\_  Thyroid Problem

Bleeding Tendencies \_\_\_\_\_  Problems with Anesthesia: Specify \_\_\_\_\_

Have you ever used Accutane (Acne Treatment) \_\_\_\_\_  Have you ever been under the care of a Psychiatrist \_\_\_\_\_

SOCIAL HISTORY:

Smoke: How long \_\_\_\_\_ How many packs a day \_\_\_\_\_ Quit Date \_\_\_\_\_

Drink: How often \_\_\_\_\_

FAMILY HISTORY: (please indicate family members –parent, sibling, grandparent, aunt or uncle with any of the following conditions):

Cancer: Specify \_\_\_\_\_  Heart Disease \_\_\_\_\_  High Blood Pressure \_\_\_\_\_

Diabetes \_\_\_\_\_  Asthma / COPD \_\_\_\_\_

**John A.P. Rimmer, MD**  
**Breast and General Surgery**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_ have received a copy of the **NOTICE OF PRIVACY PRACTICES**, given to me by the office of

John A.P. Rimmer, MD.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**AUTHORIZATION FOR (AND) RELEASE OF MEDICAL PHOTOGRAPHS / SLIDES**

**INSTRUCTIONS:**

This is a consent document that has been prepared to help inform you concerning permission for us to take photographs. It is important that you read this information carefully and completely.

**INTRODUCTION:**

Medical photographs / slides may be taken before, during or after a surgical procedure or treatment. Consent is required to take such images.

**CONSENT TO TAKE PHOTOGRAPHS:**

I hereby authorize John A.P. Rimmer, MD and / or associates to use pre-operative and post-operative photographs for professional medical purposes that are deemed appropriate including but not limited to showing these images for the purpose of medical education, patient education or during lectures to medical or lay groups. I also understand that I will remain anonymous in both name and face.

I understand that I will not be entitled to monetary payment or to any other compensation as a result of any use of these images.

PRINT PATIENT NAME: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**I hereby authorize John A.P. Rimmer, MD to release medical information to:**

\_\_\_\_\_

Relationship

\_\_\_\_\_

Relationship

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_