

JOHN A.P. RIMMER, M.D., F.R.C.S.
DIPLOMATE AMERICAN BOARD OF SURGERY

PATIENT INFORMATION

DATE: _____

NAME: _____ MALE: _____ FEMALE: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

LOCAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE:_(____)_____ WORK PHONE:_(____)_____ CELL:_(____)_____

OUT OF STATE ADDRESS: _____ PHONE:_(____)_____

CITY: _____ STATE: _____ ZIP CODE: _____

MARITAL STATUS: S M W D SPOUSE NAME: _____

EMPLOYER: _____

WORKERS COMPENSATION: YES NO IF YES, DATE OF INJURY: _____

GUARANTORS NAME (IF DIFFERENT THAN PATIENT): _____

RELATIONSHIP: _____ PHONE:_(____)_____ NEXT OF KIN: _____

REFERRING PHYSICIAN: _____

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING ASPIRIN, HERBS, AND OVER-THE-COUNTER MEDS:

LIST ANY DRUG ALLERGIES: _____

EXPLAIN REASON FOR VISIT: _____

PLEASE READ AND SIGN BELOW:

I AUTHORIZE ASSIGNMENT OF MY INSURANCE BENEFITS TO: JOHN A.P. RIMMER, M.D. I HEREBY GRANT POWER OF ATTORNEY TO JOHN A.P. RIMMER, M.D., TO MAKE INQUIRES AND REQUEST ACTION BY THE FLORIDA INSURANCE COMMISSIONER CONCERNING COLLECTION OF INSURANCE PROCEEDS DUE ME FOR MEDICAL SERVICES PROVIDED TO ME BY JOHN A.P. RIMMER, M.D., F.R.C.S.

I HAVE READ AND UNDERSTAND THE ABOVE. I ATTEST THAT I HAVE ANSWERED ALL OF THE ABOVE QUESTIONS TO THE BEST OF MY ABILITY.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

PATIENT EVALUATION

Name: _____ Age: _____ Height: _____ Weight: _____

Reason for Visit: _____

Proposed Operation: _____

PAST MEDICAL HISTORY:

Medication Allergies: _____

Previous Surgeries: _____

List of Current Medications: _____

Primary Care Dr: _____ Telephone #: _____

Date of Last Physical Exam: _____

Please Circle Yes or No:

1. Yes No Do you smoke? _____ How long: _____ Quit Date: _____
2. Yes No Do you drink alcoholic beverages? How often: _____
3. Yes No If female, could you be pregnant?
4. Yes No Have you had any prior problems with anesthesia: Specify: _____
5. Yes No Have you ever used Accutane? (Acne treatment)
6. Yes No Are you diabetic? Controlled by: _____
7. Yes No Do you have or ever had asthma? _____
8. Yes No Have you ever had difficulty breathing? _____
9. Yes No Previous TB? _____ Emphysema? _____ Pneumonia? _____
10. Yes No Do you now or have you ever had heart problems? _____
11. Yes No Have you ever been told you have a heart murmur? _____
12. Yes No Have you ever had a heart attack? _____
13. Yes No Do you get angina? _____ Chest tightness? _____
14. Yes No Do you have high blood pressure? _____
15. Yes No Do you have epilepsy? _____
16. Yes No Have you ever had a stroke? _____
17. Yes No Have you ever had thyroid problems? _____
18. Yes No Do you have palpitations or an irregular heart beat? _____
19. Yes No Do you have stomach or intestinal disease? _____
20. Yes No Do you have liver disease? _____
21. Yes No Have you ever had kidney disease? _____
22. Yes No Have you ever had any form of breast disease? _____
23. Yes No Do you now or previously had any form of cancer? _____
Please explain: _____
24. Yes No Do you have bleeding tendencies? _____
25. Yes No Do you take Aspirin? _____ How often? _____
26. Yes No Have you ever been under the care of a Psychiatrist? _____

FAMILY MEDICAL HISTORY: Mother: _____ Father: _____ Siblings: _____
Children: _____ Ages: _____

JOHN A.P. RIMMER, M.D., F.R.C.S.

PATIENT RESPONSIBILITY

BY SIGNING THIS FORM, I AGREE THAT IF MY INSURANCE COMPANY DENIES FULL OR PARTIAL PAYMENT FOR THE SERVICES RENDERED TO ME, I WILL BE FULLY RESPONSIBLE FOR PAYMENT OF SAID CHARGES. THIS CAN INCLUDE DENIAL DUE TO NON COVERED SERVICES, A NON PARTICIPATING PHYSICIAN, OR NON PARTICIPATING FACILITY.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INSURE THAT I AM SEEKING SERVICES FROM A PARTICIPATING PHYSICIAN OR FACILITY.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE

JOHN A.P. RIMMER, M.D., F.A.C.S. , F.I.C.S.
F.R.C.S, F.R.C.S, (ED.)

GENERAL, BREAST AND LAPAROSCOPIC SURGERY

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of NOTICE OF PRIVACY PRACTICES, given to me by the office of John A.P. Rimmer, M.D.

SIGNATURE OF PATIENT: _____

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, M.D. and/or associates to use preoperative and postoperative photographs for professional medical purposes that are deemed appropriate including but no 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 commiseration as a result of any use of these images.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

I hereby authorize John A. P. Rimmer, M.D to release medical information to:

Relationship

Relationship

Signed: _____ Date: _____