

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

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LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: FEMALE / MALE MARITAL STATUS: S M W D

SS#: _____ HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMPLOYER: _____ OCCUPATION: _____

EMAIL: _____

LOCAL ADDRESS:

CITY: _____ STATE: _____ ZIP: _____

OUT OF STATE ADDRESS:

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT:

NAME: _____ PHONE#: _____ RELATION: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

REFERRING PHYSICIAN: _____ 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 check (√) small box if you have had any of the following and give date in space ____)

- 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: _____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date Completed: _____ Date of Birth: _____

Please mark below if there is a **personal or family history** of any of the following cancers. If yes, then indicate family relationship and **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
<i>For example:</i> Colorectal cancer	<i>none</i>	<i>—</i>	<i>Brother</i>	<i>36 yrs</i>	<i>Aunt Cousin</i>	<i>44 yrs 58 yrs</i>	<i>Grandfather</i>	<i>65 yrs</i>

BREAST AND OVARIAN CANCER

Breast cancer

Ovarian cancer

Breast cancer in both breasts OR
multiple primary breast cancers

Male breast cancer

Are you of Ashkenazi Jewish descent? Yes No

COLON AND UTERINE CANCER

Uterine (endometrial) cancer

Colorectal cancer

Ovarian, stomach, kidney/urinary tract,
brain, OR small bowel cancer

10 or more cumulative colon polyps

MELANOMA

Melanoma

Pancreatic cancer

OTHER CANCER

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HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER BEEN TESTED FOR HEREDITARY RISK OF CANCER?

Yes No If yes, please explain: _____

FOR OFFICE USE ONLY	
<input type="checkbox"/> Patient appropriate for further risk assessment and/or genetic testing <ul style="list-style-type: none"> <input type="checkbox"/> BRACAnalysis® – A test for Hereditary Breast and Ovarian Cancer Syndrome <input type="checkbox"/> COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer) <input type="checkbox"/> COLARIS AP® – A test for Adenomatous Polyposis Syndromes <input type="checkbox"/> MELARIS® – A test for Hereditary Melanoma 	<input type="checkbox"/> Discussed hereditary cancer risk with patient <input type="checkbox"/> Patient offered genetic testing <div style="padding-left: 20px;"><input type="checkbox"/> ACCEPTED <input type="checkbox"/> DECLINED</div> <input type="checkbox"/> Follow up appointment scheduled Date: _____