

Montgomery County Medical Associates, Ltd.

Internal Medicine

5735 Rising Sun Ave.
Philadelphia, PA 19120
(215) 745-3580
(f) (215) 745-8973

WILLIAM J. GIBBONS, M.D.
GUY E. McELWAIN, JR, M.D.
DOMINICK A. GALLUZZO, M.D.
MELISSA A. JOHN, M.D.
HEIDI R. WRIGHT, C.R.N.P.

1650 Huntingdon Pike, Ste.156
Meadowbrook, PA 19046
(215) 947-7924
(f) (215) 947-0187

&
Ste. 159
(215) 947-7901
(f) (215) 947-7950

www.mcmadocs.com

8014 Burholme Ave.
Philadelphia, PA 19111
(215) 745-4500
(f) (215) 745-0188

JOHN M. BUTLER, M.D.
DAVID L. LITT, M.D.
BARBARA HOLDREN, C.R.N.P.
DONNA R. FARRELL, D.O.

Dear _____ ,

Welcome to our practice. Thank you for choosing us for your health care needs. Please complete the entire enclosed packet and **bring it to your appointment. Please do not mail it back to us.**

Your first visit will take approximately 3/4 - one hour. During that time an EKG and lab studies may also be ordered. If you have specific questions for your Dr., you may want to list them in the "Ask the Doctor" section.

Payment for your visit will depend on your insurance plan. Be sure to bring all insurance cards. You will be expected to pay your insurance copay at the time of your visit, or full payment if your insurance does not cover office visits or testing.

If you have coverage under an HMO plan or your insurance requires you to pick a primary care physician (PCP), you must make sure Montgomery County Medical Associates is listed on your card. This must be *done PRIOR* to your visit to assure that you have coverage with our practice or you will be responsible for the cost of your visit and testing if seen. If you have not chosen Montgomery County Medical Associates prior to your visit, you will be asked to reschedule.

Our new patients are allotted an extended amount of time so that our Doctors and Nurse Practitioners can address all your questions and concerns during your physical. Therefore, cancellations must be made **24 hours** prior to your visit or you will be charged accordingly. Cancellation notice allows us ample time to schedule other patients needing an appointment.

We look forward to meeting you. If you have any questions, please do not hesitate to call our staff at 215-947-7924.

Thank you.

Dr. _____ /N.P. _____ will see you at:

Location _____

Date _____ Time _____

MONTGOMERY COUNTY MEDICAL ASSOCIATES, LTD

PATIENT PROFILE UPDATE

PLEASE PRINT CLEARLY

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

ADDRESS _____

EMAIL ADDRESS: _____

TELEPHONE HOME: _____ WORK: _____

CELL: _____

EMERGENCY CONTACT NAME _____ PHONE# _____ RELATIONSHIP _____

RACE ___ American Indian/Alaska Native ___ Asian ___ Pacific Islander ___ Black/African American ___ White ___ Hispanic ___ Other

ETHNICITY ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Refuse to report

LANGUAGE ___ English ___ Indian (includes Hindi & Tamil) ___ Other ___ Russian ___ Spanish

1. PHARMACY NAME _____ PHARMACY LOCATION _____

PHARMACY PHONE # _____ FAX # (IF KNOWN) _____ MAIL ORDER

2. PHARMACY NAME _____ PHARMACY LOCATION _____

PHARMACY PHONE # _____ FAX # (IF KNOWN) _____ MAIL ORDER

INSURANCE NAME: _____ NAME OF CARDHOLDER _____ D.O.B _____
PRIMARY RELATIONSHIP _____

INSURANCE NAME: _____ NAME OF CARDHOLDER _____ D.O.B _____
SECONDARY RELATIONSHIP _____

FINANCIALLY RESPONSIBLE PERSON NAME: _____ D.O.B. _____ RELATIONSHIP _____

CHECK BOX IF SAME AS ABOVE ADDRESS: _____ PHONE # _____

PATIENT OR AUTHORIZED PERSON SIGNATURE _____ DATE: _____

PATIENT NAME _____ HOME PHONE _____
 ADDRESS _____ WORK PHONE _____
 DATE OF BIRTH _____
 INSURANCE _____ REFERRED BY _____ SS # _____

INSTRUCTIONS: PUT IN THOSE BOXES APPLICABLE TO YOU IN THE "YES" OR "NO" SPACE. IF LINES ARE PROVIDED WRITE IN YOUR ANSWER.

FAMILY HISTORY

	FATHER	MOTHER	BROTHER				SISTER				SPOUSE	CHILDREN						
			1	2	3	4	1	2	3	4		1	2	3	4	5	6	
AGE (IF LIVING)																		
HEALTH (G) GOOD (B) BAD																		
CANCER																		
TUBERCULOSIS																		
DIABETES																		
HEART TROUBLE																		
HIGH BLOOD PRESSURE																		
STROKE																		
EPILEPSY																		
NERVOUS BREAKDOWN																		
ASTHMA; HIVES, HAY FEVER																		
BLOOD DISEASE																		
AGE (AT DEATH)																		
CAUSE OF DEATH																		

PERSONAL HISTORY

- Please circle if you have had problems with or are presently complaining of any of the following:
- | | | | |
|-------------------------------|--------------------------|----------------------------------|-----------------------|
| 1. High blood pressure | 13. Bronchitis | 26. Change in bowel habits | 38. Arthritis |
| 2. Diabetes | 14. Pneumonia | 27. Unexplained weight gain/loss | 39. Low back problems |
| 3. Cancer | 15. Persistent cough | 28. Hemorrhoids | 40. Skin diseases |
| 4. Heart disease | 16. T.B. | 29. Gall bladder disease | 41. Blood disorders |
| 5. Chest pain/chest tightness | 17. Hay fever | 30. Colitis | 42. Venereal diseases |
| 6. Shortness of breath | 18. Abdominal discomfort | 31. Hepatitis or jaundice | 43. Anxiety |
| 7. Swollen ankles | 19. Indigestion | 32. Thyroid disease | 44. Depression |
| 8. Palpitations | 20. Nausea | 33. Head or neck radiation | 45. Anemia |
| 9. Lightheadedness | 21. Vomiting | 34. Headache | 46. Alcohol abuse |
| 10. Frequent urination | 22. Constipation | 35. Kidney disease | 47. Drug abuse |
| 11. Rheumatic fever | 23. Diarrhea | 36. Kidney stones | 48. Gout |
| 12. Asthma | 24. Blood in stool | 37. Difficulty urinating | 49. _____ |
| | 25. Ulcers | | 50. _____ |

HOSPITALIZATIONS / OPERATIONS

Please List and Supply the Dates of:
 Operations: _____
 Hospitalizations other than for surgery: _____

ALLERGIES

ARE YOU ALLERGIC TO	YES	NO	ARE YOU ALLERGIC TO	YES	NO	ARE YOU ALLERGIC TO	YES	NO
<input type="checkbox"/> PENICILLIN <input type="checkbox"/> SULFA DRUGS			ANY OTHER DRUGS			ANY FOODS		
<input type="checkbox"/> ASPIRIN <input type="checkbox"/> CODEINE <input type="checkbox"/> MORPHINE			EXPLAIN			EXPLAIN		
<input type="checkbox"/> MYCINS <input type="checkbox"/> OTHER ANTIBIOTICS								
<input type="checkbox"/> TETANUS <input type="checkbox"/> ANTITOXIN <input type="checkbox"/> SERUMS			ADHESIVE TAPE			<input type="checkbox"/> NAIL POLISH <input type="checkbox"/> OTHER COSMETICS		

Allergies to Medications, X-Ray Dyes, or Other Substances No Yes

PREVENTION

- Do you wear seat belts? No Yes If no, why not? _____
- Do you wear a bike helmet? No Yes N/A
- Do you smoke? No Yes If yes, how many packs per day? _____
- Do you drink alcoholic beverages? No Yes If yes, how much per week? _____
- Do you drink coffee? No Yes If yes, how many cups per day? _____
- Do you drink tea? No Yes If yes, how many cups per day? _____
- If there is a gun in your home, do you keep it unloaded and out of children's reach? No Yes N/A
- Do you use drugs? (marijuana, cocaine, crack, etc.) No Yes If yes, explain: _____
- Have you ever engaged in any activity which has put you at risk of getting AIDS? No Yes If yes, explain: _____
- Do you wish to be tested for AIDS? No Yes
- Have you ever worked with chemicals, paints, asbestos, or other hazardous material? No Yes If yes, explain: _____
- Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? No Yes
- Do you ever feel afraid of your partner? No Yes N/A
- Do you have a "living will"? No Yes
- Do you have a donor card? No Yes

Method of birth control? _____

When was your last:
 Pap smear? _____ Self testicular exam? _____
 Mammogram? _____ Breast exam? _____ Stool check for blood? _____
 Cholesterol check? _____ Prostate exam? _____

- Do you have properly installed and tested smoke detectors? No Yes
- Set hot water heater to 120-130°F? No Yes
- Regular dental visits? No Yes
- Avoid excessive sun exposure? No Yes
- Are you at risk for falls? No Yes
- Do you exercise? No Yes
- Do you eat a healthy diet? No Yes
- Are you fatigued? No Yes
- Have you had your hearing tested? No Yes
- Have you had your vision screened? No Yes
- Have you had foot care? No Yes
- Have you had shoulder function screening? No Yes
- Have you had a flexible sigmoidoscopy? No Yes
- Have you had a colonoscopy? No Yes

IMMUNIZATION

Immunization history – have you had:

PPD? Yes No When? _____ Pneumovax immunization? Yes No When? _____

Hepatitis B? Yes No When? _____ Flu immunization? Yes No When? _____

Other? Yes No When? _____ Tetanus immunization? Yes No When? _____

WOMEN ONLY

Gynecologic and Obstetric History

Age at onset of periods: _____ Hormone Therapy? _____

Pregnancies: _____ Births: _____ Length of period: _____

Miscarriages: _____

Prolonged or abnormal bleeding: No Yes (Please describe): _____

Leakage of urine: No Yes (Please describe): _____

Pelvic pain: No Yes (Please describe): _____

Abnormal discharge: No Yes (Please describe): _____

History of abnormal Pap smear: No Yes (Type of treatment): _____

MEDICINE LOG

MY LIST OF MEDICATIONS STRENGTH TIME/DAY

QUESTIONS FOR THE DOCTOR

ALLERGIES TO MEDICATION

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CONSENT FOR PURPOSE OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS
HIPPA COMPLIANCE

I consent for the use or disclosure of my protected health information by Montgomery County Medical Associates, Inc.(further known as MCMA) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of MCMA. I understand that diagnosis or treatment by Drs. William Gibbons, Guy McElwain, Dominick Galluzzo, David Litt, John Butler, Donna Farrell, Melissa John and Nurse Practitioners Barbara Holdren & Heidi Wright (further known as providers) may be condition upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. MCMA. is not required to agree to the restrictions that I may request. However, if Montgomery County Medical Associates, Ltd. agrees to a restriction that I request, the restriction is binding on MCMA and its providers.

I have the right to revoke this consent, in writing, at any time, except to the extent that said provider and MCMA has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my provider, another health care provider, a health plan or future physical or my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review MCMA's Notice of Privacy Practices prior to signing this document. MCMA's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of MCMA. The Notice of Privacy Practices for MCMA is also on the wall in the reception area. The Notice of Privacy Practices also describes my rights and MCMA's duties with respect to my protected health information.

MCMA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next visit.

Name of Patient _____
(Please Print)

Signature of Patient _____

OR

Signature of Responsible Authority _____ Relationship _____

Date _____

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PATIENT FINANCIAL RESPONSIBILITY

I FULLY UNDERSTAND THAT I AM RESPONSIBLE TO PROVIDE ACCURATE AND COMPLETE INSURANCE INFORMATION TO THIS OFFICE AS APPLIES. I ALSO UNDERSTAND THAT IF MY INSURANCE REQUIRES ME TO PAY A COPAY UNDER MY CONTRACT, IT IS TO BE PAID AT THE TIME SERVICES ARE PROVIDED.

I ALSO UNDERSTAND THAT ANY AND ALL SERVICES PROVIDED THAT ARE NOT COVERED BY AN INSURANCE PLAN, IS MY RESPONSIBILITY, AND PROMPT PAYMENT IS TO BE MADE TO THIS OFFICE. IF PAYMENT IS NOT MADE WITHIN 30 DAYS, MY ACCOUNT WILL BE HANDED OVER TO A COLLECTION AGENCY.

Name of Patient _____
(Please Print)

Signature of Patient _____

OR

Signature of Responsible Authority _____ Relationship _____

Date _____

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CONSENT TO RELEASE MEDICAL INFORMATION

I _____ HEREBY GRANT MONTGOMERY COUNTY
MEDICAL ASSOCIATES TO DISCUSS ANY / ALL MEDICAL INFORMATION TO
_____ RELATIONSHIP _____

VIA TELEPHONE, MAIL OR OFFICE VISIT, ON MY BEHALF.

OR

CHECK BOX IF MEDICAL INFORMATION IS NOT TO BE RELEASED.

Name of Patient _____
(Please Print)

Signature of Patient _____ DATE _____

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PRESCRIPTION CONSENT FORM

ePrescribing

By signing this consent form you are agreeing that Montgomery County Medical Associates, Ltd. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent Montgomery County Medical Associates, Ltd. to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Name of Patient _____
(Please Print)

Signature of Patient _____ DATE _____

OR

Signature of Responsible Party _____