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. GIBBONS, DNP, CRNP

1650 Huntingdon Pike, Ste.156
Meadowbrook, PA 19046
215-947-7924
(f)215-947-0187
&
Ste.159
215-947-7901
(f)215-947-7950

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, DrNP, CRNP
JULIANNE RUTZ, CRNP

www.mcmadocs.com

Welcome to our practice and thank you for choosing MCMA for your health care needs. Please complete the entire enclosed packet and **bring it to your appointment. Please DO NOT mail to the office.**

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.

Thank you.

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:_____

_____

TELEPHOHE 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
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney disease
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. _____
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
☐ PENICILLIN ☐ SULFA DRUGS			ANY OTHER DRUGS			ANY FOODS		
☐ ASPIRIN ☐ CODEINE ☐ MORPHINE			EXPLAIN			EXPLAIN		
☐ MYCINS ☐ OTHER ANTIBIOTICS								
☐ TETANUS ☐ ANTITOXIN ☐ SERUMS			ADHESIVE TAPE			☐ NAIL POLISH ☐ 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 colonscopy?	☐ 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: _____ Frequency: _____ Length of period: _____

Births: _____ 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): _____

This information is for use by your physician as part of your confidential medical record.

MY LIST OF MEDICATIONS STRENGTH & TIMES PER DAY

QUESTIONS FOR THE DOCTOR

ALLERGIES TO MEDICATION

OTHER CURRENT DOCTORS OR SPECIALISTS

(PLEASE LIST NAME, SPECIALTY AND LOCATION OR PHONE #)

MONTGOMERY COUNTY MEDICAL ASSOCIATES, LTD.

WILLIAM J.GIBBONS,M.D.
GUY E.McELWAIN,JR,M.D
DOMINICK A.GALLUZZO,M.D.
MELISSA A.JOHN,M.D.

JOHN M. BUTLER,M.D.
DAVID L.LITT,M.D.
BARBARA HOLDREN, DrNP, CRNP
HEIDI R. GIBBONS, DNP, CRNP
JULIANNE RUTZ, CRNP

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 _____

MONTGOMERY COUNTY MEDICAL ASSOCIATES, LTD.

WILLIAM J.GIBBONS,M.D.
GUY E.McELWAIN,JR,M.D
DOMINICK A.GALLUZZO,M.D.
HEIDI R. GIBBONS, DNP, CRNP
MELISSA A.JOHN,M.D.

JOHN M. BUTLER,M.D.
DAVID L.LITT,M.D.
BARBARA HOLDREN, DrNP, CRNP
JULIANNE RUTZ, CRNP

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 _____

MONTGOMERY COUNTY MEDICAL ASSOCIATES, LTD.

WILLIAM J.GIBBONS,M.D.
GUY E.McELWAIN,JR,M.D
DOMINICK A.GALLUZZO,M.D.
HEIDI R. GIBBONS, DNP, CRNP
MELISSA A.JOHN,M.D.

JOHN M. BUTLER,M.D.
DAVID L.LITT,M.D.
BARBARA HOLDREN, DrNP, CRNP
JULIANNE RUTZ, CRNP

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_____

MONTGOMERY COUNTY MEDICAL ASSOCIATES, LTD.

WILLIAM J.GIBBONS,M.D.
GUY E.McELWAIN,JR,M.D
DOMINICK A.GALLUZZO,M.D.
HEIDI R. GIBBONS, DNP, CRNP
MELISSA A.JOHN,M.D.

JOHN M. BUTLER,M.D.
DAVID L.LITT,M.D.
BARBARA HOLDREN, DrNP, CRNP
JULIANNE RUTZ, CRNP

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_____