Welcome to Old Dominion Osteopathic Medicine!

Enclosed you will find the following forms:

- Patient Registration Form
- Insurance Information
- Consent for Treatment
- Disclosure Authorization, Confidentiality Agreement, and HIPAA Notice
- Medical History

We know that you prefer to be seen at your scheduled time, so please plan on arriving **30 minutes prior to your scheduled appointment time**, as well as taking a few minutes to complete the following forms prior to your first appointment with us, if at all possible. Having these forms completed upon arrival will keep your waiting time to a minimum.

For your first appointment, please come prepared with the following items:

- Any lab work completed within the last 6 months.
- The attached forms, completed as fully as possible.
- Your Insurance Card
- A Picture ID (Military ID or Driver’s License)
- If possible, a bag containing all current medications, including over-the-counter and vitamin supplements, or a complete list if you cannot bring the items with you.
- Payment for your specialist office visit co-pay. We accept checks, cash, Master Card, and Visa. If you do not know how much your co-pay will be, feel free to call us ahead of time and we can look it up for you.

If possible, please wear loose, comfortable clothing and drink plenty of water the day of your appointment.

Also, please note: if you are **more than 10 minutes late** for your scheduled appointment time, you will have to be rescheduled. Unfortunately, due to time constraints, there will be no exceptions to this rule.

Thank you for selecting Old Dominion Osteopathic Medicine. We look forward to meeting you soon.

Sincerely,

Jason A. Sneed, D.O.
540-322-5040
Patient Information:

First Name _______________________  MI ___ Last Name _______________________
Date of Birth: _____/_____/______  Sex: M / F  Social Security #:______ - ____ - ____
Address: __________________________________________________
City: _______________ State: ___  Zip: __________
Home Phone: ______-_____ -______  Cell/Work Phone: ______-_____ -______
Which number would you prefer we contact you on? __________
Email: ______________________________________________________

We will never sell, share, trade, or use your information for anything other than what you have explicitly granted us
permission for. Please note that all emails are unencrypted and thus vulnerable to third-party interception.

May we email you reminders for your appointments? Y / N
May we email you our monthly newsletter and practice notifications? Y / N
How did you hear about us? ______________________________________

Emergency Contact Information:

Name: __________________________________________ Relationship: ________________________
Phone: ______-_____ -______ or ______-_____ -______

Do you have a Power of Attorney? Y / N
If YES, please provide: Name: _______________________  Date Effective: __/__/____

(For Patients Under Age 18) Responsible Party Information:

Last Name _______________________  First Name _______________________  MI ___
Date of Birth: _____/_____/______  Social Security #:______ - ____ - ____
Address: __________________________________________________
City: _______________ State: ___  Zip: __________
Home Phone: ______-_____ -______  Cell/Work Phone: ______-_____ -______
Meaningful Use Information:
Disclosure of meaningful use information is completely voluntary. Choosing not to disclose the following information will not in any way effect your medical treatment.

Language: □ Decline to Answer □ English □ Spanish
□ French □ German □ Chinese
□ Italian □ Japanese □ Korean
□ Portuguese □ Russian □ Other: ________________

Race: □ Decline to Answer □ Unknown
□ Black or African American □ Black Hispanic or Latino
□ American Indian or Alaskan Native □ Native Hawaiian
□ Filipino □ Guamanian
□ Samoan □ Tongan
□ Other Pacific Islander □ Vietnamese
□ Chinese □ Japanese
□ Korean □ Other Asian
□ White □ White Hispanic or Latino

Ethnicity: □ Decline to Answer □ Hispanic or Latino □ Not Hispanic or Latino

Student Shadows:
Old Dominion Osteopathic Medicine is an Osteopathic Rotation site for future DO physicians, both those in the process of applying to medical school as well as those completing their medical education at accredited Osteopathic medical schools. As such, we may have students shadowing Dr. Sneed to learn about his holistic approach to medicine using OMM.

Initial here if you agree to allow students to participate in your care, realizing that if at any point you become uncomfortable you can ask the student to leave, or let Dr. Sneed or his staff know, with no ramifications upon your care.

______________

OR

Initial here if you decline to allow students to participate in your care, knowing that this in no way will affect the care you receive.

______________
Authorization to Use or Disclose Protected Health Information:
Old Dominion Osteopathic Medicine, PLLC, its physicians and staff are hereby authorized to disclose protected health information with those listed below. Permission may be revoked at any time in writing.

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<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
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Pharmacy:
Name: __________________________________________ Phone: _____ - _____ - ________
Address: __________________________________________
City: _________________________ State: ____ Zip:__________

Primary Care Physician:
Name: __________________________________________ Phone: _____ - _____ - ________
Practice Name: __________________________________________
Address: __________________________________________
City: _________________________ State: ____ Zip:__________

While Dr. Sneed can handle many of your medical needs, similar to those of a primary care physician (PCP), we do recommend that you have a separate PCP. We are more than happy to discuss natural alternatives and even some medications for most problems, but these should always be discussed with your PCP as well. If you choose to not have a PCP in addition to this practice, it is imperative that you realize that natural alternatives are not a part of standard medical care and by accepting such recommendations you are accepting the potential risks and benefits that come with deviation from standard medical care.

_________________________________________ /______/_______
Patient/Authorized Party Relationship Date
Insurance Information

**Primary Insurance:**
Policy Number: ___________________________ Group Number: ___________________________
Policy Holder: Last Name ___________________ First Name _______________________
Policy Holder DOB: _____/_____/______ Relationship to Patient: _______________________

**Secondary Insurance:**
Policy Number: ___________________________ Group Number: ___________________________
Policy Holder: Last Name ___________________ First Name _______________________
Policy Holder DOB: _____/_____/______ Relationship to Patient: _______________________

**Important Payment Notice -- Signature Required:**

Assignment of Insurance Benefits: I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Old Dominion Osteopathic Medicine, PLLC for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Center for Medicare and Medicaid Services, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file.

Guarantee of Payment: I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

Cancellation Policy: In the event that you are unable to keep your scheduled appointment, please notify us within 24 hours of your appointment time. If you are unable to keep your appointment time and you do not call and give at least a 24-hour notice, our office has the following policy:

First Absence: You will be notified via phone of your missed appointment.
Second Absence: You will be notified by mail of your missed appointment.
You will also receive a $50.00 office charge.
Third Absence: You will be notified by mail of your missed appointment.
You will also receive a $50.00 office charge.
Fourth Absence: You will be notified by mail of your missed appointment.
You will also receive a $50.00 office charge.
You will be discharged from our practice.

Signature of responsible party: ___________________________ Date: _____/_____/______
Name of Policy Holder: ___________________________ Social Security #: ______-____-_______
Name of Person Signing: ___________________________ Relationship: ______________________
Consent for Treatment

**General Consent for Treatment and Tests:** I consent to treatment by Old Dominion Osteopathic Medicine, PLLC, physicians and staff for my illness and/or health evaluations, including but not limited to x-rays, blood tests, laboratory procedures, medications, and minor procedures. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcomes of my medical care. I understand that State Law requires physicians to report certain communicable diseases to the Health Department.

**Release from Liability for Leaving Against Medical Advice:** I agree that if I leave a physician’s office against the advice of my physician or Old Dominion Osteopathic Medicine, PLLC, then Old Dominion Osteopathic Medicine, PLLC, its personnel, and my physician(s) are released from responsibility or liability for any injuries or damages which may result from my leaving against medical advice.

**Phone Authorization:** I authorize Old Dominion Osteopathic Medicine, PLLC to contact me by phone. I understand if I cannot be reached, a message may be left at my designated phone number.

**Email:** I understand that any email communications between myself and the staff of Old Dominion Osteopathic Medicine are unencrypted, and thus vulnerable to third party interception. Should I request medical information be sent to me via email, I hereby release Old Dominion Osteopathic Medicine and its staff from liability should it be intercepted by a third party.

**Confidentiality Agreement:** Old Dominion Osteopathic Medicine, PLLC, its physicians and staff may publicly call your (or your child’s) name in the waiting room of Old Dominion Osteopathic Medicine, PLLC.

**Notice of Privacy Practices:** By signing this document, I also acknowledge that I have received the attached copy of the Privacy Practices of Old Dominion Osteopathic Medicine, PLLC and HIPAA Notice, as required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I have read and understand this document, and agree to its terms.

_____________________________  _____________________  ____/_____/_______
Patient/Authorized Party        Relationship        Date
Reason for your visit today:
______________________________________________________________________________
______________________________________________________________________________

Review of Systems: (check all that currently apply, please explain further in space below)

☐ Unexplained Weight Changes
☐ Heat/Cold Intolerance
☐ Fatigue
☐ Trouble Sleeping
☐ Dizziness
☐ Fever
☐ Headaches/Migraines
☐ Sinus Problems
☐ Eye Problems
☐ Ear Problems
☐ Neck Pain
☐ Back Pain
☐ None of the above

☐ Heart Problems
☐ Respiratory Problems
☐ Chest Pain
☐ Anxiety/Depression
☐ Pain in Extremities
☐ Muscle Problems
☐ Memory Problems
☐ Decreased Libido/Sexual Difficulties
☐ Abdominal/Gastrointestinal Problems
☐ Urinary Problems
☐ Swelling
☐ Other

☐ None of the above
Prior Medical History: (check all that apply)

☐ High Cholesterol  ☐ High Blood Pressure  ☐ Asthma  ☐ Diabetes  
☐ Other: ____________________________________________________________

Past Traumas: (Major Falls, Motor Vehicle Accidents, etc.)

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<tr>
<th>Incident</th>
<th>Date</th>
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Surgical History: (Please list all surgeries)

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<th>Surgery</th>
<th>Date</th>
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Screenings:

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<tr>
<th>Pap Smear</th>
<th>Date of Last Screening</th>
<th>Results</th>
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<tr>
<th>Mammogram</th>
<th>Date of Last Screening</th>
<th>Results</th>
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<tr>
<th>Colonoscopy/Colon Cancer Screening</th>
<th>Date of Last Screening</th>
<th>Results</th>
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<tr>
<th>Prostate Cancer Screening</th>
<th>Date of Last Screening</th>
<th>Results</th>
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<tr>
<th>Bone Density (Dexa) Scan</th>
<th>Date of Last Screening</th>
<th>Results</th>
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Please list any medical issues not previously addressed:

______________________________________________________________________________
______________________________________________________________________________
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Social History: (Please check all that apply)

Tobacco Use:  □ Never
  □ Former: Packs/Day _____ Years Smoking: _____
    Date Quit: ______/______/_______
  □ Current Packs/Day: _____ Years Smoking: _____
  □ Other Tobacco Use:______________________________

Alcohol Status:  □ Never  □ No Current Use  □ One or Less Per Day
  □ Two or Less Per Day  □ More than 2 Per Day

Recreational Drug Use:  □ No
  □ Yes If Yes, Type/Frequency: ______________________

Employment:  □ Full-Time  □ Part-Time  □ Self-Employed  □ Unemployed
  □ Disabled  □ Retired  □ Stay-At-Home Parent  □ Student

Marital Status:  □ Never Married  □ Currently Married  □ Divorced
  □ Widowed  □ Separated  □ Committed Relationship

Family History:

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<tr>
<th>Relation</th>
<th>Medical Conditions</th>
<th>Age Deceased</th>
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<td>Mother</td>
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<td>Father</td>
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<td>Siblings</td>
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### Allergies to Medications:

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<th>Medication</th>
<th>Allergic Reaction</th>
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### Medications & Supplements:

*If possible, please bring in all prescription, over-the-counter, vitamins, and supplement bottles.*

<table>
<thead>
<tr>
<th>ALL Prescriptions, Over-The-Counter Medications, Vitamins, and Supplements</th>
<th>Dosage (mg, iu)</th>
<th>Quantity &amp; Frequency (How many, How often)</th>
<th>Prescribed By:</th>
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