|  |  |
| --- | --- |
| **All Fields are required unless marked (Optional).** | |
|  |  |
| **In the last 14 days, have you had contact with someone who has a suspected or confirmed case of covid-19?** | |
| Yes | No |
|  |  |
| **Have you been asked or referred to get tested by a healthcare provider?** | |
|  |  |
| Yes | No |
|  |  |
| **Have you experienced any symptoms in the last 14 days?** | |
|  |  |
| Yes | No |
|  |  |
| **Are you currently pregnant? (Optional)** | |
|  |  |
| Yes | No  Not Applicant |
|  | |
| **Is this test for travel purposes?** | |
|  |  |
| Yes | No |
|  |  |
| **Do you have health insurance coverage? This includes private health insurance, Medicare plans and Medicaid plans.** | |
|  |  |
| Yes | No |
|  |  |
| **If the test is positive, would you like to schedule a virtual visit with our Infectious Disease providers?** | |
|  |  |
| Yes | No |
|  |  |
| **I acknowledge that I have answered these questions truthfully to the best of my knowledge.** | |
|  |  |
|  |  |
| |  |  | | --- | --- | |  |  | | **Full Name** | **Date of Birth** | | |
|  |  |
| |  |  | | --- | --- | |  |  | | **Signature** | **Today Date** | | |
|  |  |
|  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION**   If using insurance, please enter your as it appears on your insurance card | | | | | | |
| **First Name:** |  | | | | | |
| **Last Name:** |  | | | | | |
| **Date of Birth:** |  | | | | | |
| **Email:** |  | | | | | |
|  |  | | | | | |
| **Your relationship to the patient:** | I am the patient  Parent of the patient   Legal guardian of the patient  Auth representative of the patient | | | | | |
| **Address:** |  | | | | | |
| **Address:** |  | | | | | |
| **City:** | **State:** | | | **Zip Code:** | | |
|  |  | | | | | |
|  |  | | | | | |
|  |  | | | | | |
| **The CDC requires us to collect this info to see how COVID-19 impacts our communities.** | | | | | | |
| **Gender:** | Male | Female | | | Prefer not to answer | |
|  |  | | | | | |
| **Ethnicity:** | Hispanic or Latino | | | | | |
|  | I don’t want to answer | | | | | |
|  | Not Hispanic or Latino | | | | | |
|  | I don’t know | | | | | |
|  |  | | | | | |
| **Race:** | American Indian or Alaska Native  Black or African American  Native Hawaiian or Other Pacific Islander  Hispanic  Asian  White or Caucasian  I don’t want to answer  I don’t know  Other | | | | | |
|  |  | | |  | | |
|  | | | | | | |
| Your contact information is only used for messages about this test. We’ll call your mobile number when we have your results. | | | | | | |
|  |  | | | | | |
| **MOBILE NUMBER: ( ) -** | | | | | | |
|  | | | | | | |
| **CAN WE LEAVE VOICEMAIL IF NO ANSWER?** | | | Yes | | | No |
|  | | | | | | |
| By giving your mobile number, you agree to receive calls about this and follow-up visits, test results, healthcare, account and insurance, and agree to the Terms of Use and Privacy Policy.  **HEALTH INSURANCE**  We bill your insurance or a federal program so that it’s no cost to you. | | | | | | |
|  | | | | | | |
| **Primary Insurance:** | | | | | | |
| **Subscriber Number:** | | | | | | |
|  | | | | | | |
| **Secondary Insurance:** | | | | | | |
| **Subscriber Number:** | | | | | | |
| **Third Insurance:** | | | | | | |
| **Subscriber Number:** | | | | | | |
|  | | | | | | |
| **INFO ON COVID-19’s HEALTH IMPACT**  These questions help us fulfill our reporting requirements to the CDC and other state or federal agencies. They help us see the impact of COVID-19 on our health and the effectiveness of vaccines. | | | | | | |
| **Do you work in healthcare?** | Yes | | | No | | |
|  | | | | | | |
| **Are you a resident in a special setting where the risk of COVID-19 transmission may be high? (Optional)** | | | | | | |
|  | Yes | | | No | | |
|  | | | | | | |
| **This may include long-term care, correctional and detention facilities; homeless shelters; assisted-living facilities and group homes?** | | | | | | |
|  | Yes | | | No | | |
|  |  | | |  | | |
| **Have you received a COVID-19 vaccine?** | Yes | | | No | | |
|  | | | | | | |
| **Leave a detailed voicemail with my results if I miss your call.** | Yes | | | No | | |
|  |  | | |  | | |
| **If YES, please provide the Facility Name(s), Phone Number(s) and Fax Number(s) below:** | | | | | | |
|  | | | | | | |
|  | | | | | | |
| **Please write your initials to show that you agree with the following statements:** | | | | | | |

|  |  |
| --- | --- |
|  | I’m consenting to test for COVID-19 –voluntarily– and can decline any tests at any time. |
|  | My test results will be reported to the state health department where required by law. |
|  | A copy of the Notice of Privacy Practices has been made available to me. |