|  |
| --- |
| **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** |

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|  |  |
|  |  |

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| --- |
| **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. |