

2020-2021 COVID-19 Testing Registration Form



REQUIRED INFORMATION FOR PATIENT RECEIVING TEST

RN/Paramedic signature _____

REGUIRED IN ORMATION FOR FATIENT REGE	IVIIVO I LOI
Release of information I understand that today's COVID-19 test results and any subsequent test results will be shared with for the purpose of surveillance and ongoing care. By initialing below, I	
·	urveillance and origoning care. By initialing below, i
consent to this release of my information.	
(initial)	
Last name	First name
Middle name SSN – last 4 digits	Sex (M/F) Date of birth (MM/DD/YYYY) Age
Address	
City	State Zip
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Phone ☐ Home or ☐ Cell	
INSURANCE INFORMATION	
Patient is uninsured:	Policy holder ☐ Self (skip section below) ☐ Spouse ☐ Parent ☐ Othe
Primary insurance company name	Policy holder last name
Insurance ID#	First name
Group #	Date of birth (MM/DD/YYYY)
I had an opportunity to review general information on COVID-19 today and ask questions and received answers to my satisfaction. I understand the benefits and risks of being tested for COVID-19 and expressly authorize a paramedic or nurse to collect a sample for testing.	
Signature	Date

Date____