COVID-19 TESTING PATIENT INTAKE FORM

PLEASE FILL THIS IN WITH THE NAME OF THE STUDENT OR STAFF MEMBER AT ST. MARTIN DE PORRES MARIANIST SCHOOL. WRITE NEATLY PLEASE. ALL INFORMATION MUST BE COMPLETED.

FIRST NAME: _____ LAST NAME: _____ IF A STUDENT, HOMEROOM: ___

ADDRESS: _____

HOME TELEPHONE NUMBER: _____ IS THIS A MOBILE NUMBER: YES NO

MAY HEALHCARE LOGICS SEND TEXT MESSAGES TO THIS NUMBER AS NEEDED?: YES NO

EMAIL ADDRESS: _____

EMERGENCT CONTACT/LEGAL GUARDINAN:

FULL NAME: _____ RELATIONSHIP: _____ CONTACT NUMBER: _____

INSURANCE INFORMATION (YOUR INSURANCE WILL BE BILLED FOR THE SERVICE):

NAME OF INSURANCE PROVIDER: _____ MEMBER ID: _____

GROUP NUMBER: _____

IF POSSIBLE, PLEASE TAKE A PHOTO OR PHOTOCOPY FRONT OF CARD AND STAPLE THE PHOTO OR PHOTOCOPY HERE.

PRIMARY PHYSICIAN:

NAME: _____ CONTACT: _____

By signing, I agree with Healthcare Logics LLC and all efforts of COVID-19 testing at St. Martin de Porres Marianist School. I recognize that Healthcare Logics in responsible for testing only. All medication and procedure adjustments are the responsibility of the primary care physician. I agree to allow Healthcare Logics to share pertinent information with my primary care physician and St. Martin de Porres Marianist School as needed. I agree to allow representatives of St. Martin de Porres Marianist School to receive my/my child's testing results conducted by Healthcare Logics.

This authorization to provide COVID-19 services shall run through and including June 30, 2021.

Name: _____

Signature: _____

Date: _____

For all minors 14 and under, a parent or legal guardian must sign this form.