COVID Mobile Testing

ALL Patients Complete Section 1

SECTION 1

Date: _____ Testing Location: _____

☐ I consent to being tested for COVID

☐ I consent to receive text messages about my care (including results)

First Name: _____ Last Name: _____

Preferred Name: _____ Email: _____

Date of Birth: _____ Patient's

Mobile/Cell#: _____ Signature: _____

Parent/Guardian's Name: _____ Parent/Guardian's Signature: _____

SECTION 1

Are you experiencing any Symptoms? ☐ yes ☐no

Do you have Medicare or Medicare Advantage Plans? ☐ yes ☐ no

If yes, please provide your Medicare ID_____

I understand I can review CHC's Notice of Privacy Practices online at: https://www.chc1.com/privacy-statement/

New Patient Info: New Patients ONLY Complete Sections 2 & 3

SECTION 2

Sex ☐ Male ☐ Female ☐ Other

Race
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ White
- ☐ Native Hawaiian or Other Islander
- ☐ Declined
- ☐ Unspecified
- ☐ Other _____

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined
- ☐ Unspecified
- ☐ Other _____

SECTION 2

Address: _____

City / State / Zip Code: _____

Home Phone #: _____

Parent / Guardian Information

SECTION 3

First Name: _____ Last Name: _____

Mobile/Cell#: _____ Email: _____

☐ Address Same as Above

Address: _____

City / State / Zip Code: _____

SECTION 3