Registration Office Use Only:

MR# ____________________

Registered by________________

Date ____________

This is a COVID testing service only and not intended to provide medical evaluation or treatment. If you are in need of a medical examination, or if you would like to see a medical provider or are seeking treatment for a medical condition, please go to our emergency department or call your primary care doctor.

Facility: ____ **Date Submitted:** ______________________________

Patient Name: ______________________________ **Gender** ☐ M ☐ F **Date of Birth**: ____________ Age: _____

Social Sec. #:______________________________

Address: ______________________________ City: ______________________ State:_____ Zip: _____________

Home Phone: ____________________Work Phone: __________________ Other Phone: ____________________

Email Address: ____

Responsible Party Information:

Relationship To Patient:____

Name:____

Date of Birth:______________ **Social Sec. #:**_________________________

Insurance Information

Insurance #1 ____ Policy # ______________________________

Subscriber**:**________________________ Patient Relationship To Insured:_______________________

Insurance #2 ____ Policy # ______________________________

Subscriber**:**________________________ Patient Relationship To Insured:_______________________