



COVID-19 TESTING – PATIENT INTAKE

* Please be thorough and write legibly *

Last Name _____ First Name _____ MI _____ DOB _____ SSN _____

Address _____ City _____ State _____ Zip _____ County _____

I have already set up a *Patient Portal* account Yes No (if unanswered, your portal will be reset)

- Sex**
- Male
 Female
 Other
- Race**
- White
 Black/African American
 Asian
 American Indian/Alaska Native
 Native Hawaiian/Islander
 Declined
 Unavailable/Unknown

- Ethnicity**
- Hispanic/Latino
 Non-Hispanic/Latino
 Declined
 Unavailable/Unknown

Person responsible for receiving results:

Full Name _____ DOB _____

Phone _____

Email _____

* Email is required if you wish to use the *Patient Portal*

Check here if you are the parent/guardian/spouse of the person being tested and want him/her to appear in your portal.

TEST QUESTION	ANSWER OPTIONS	NOTE / DETAILS
Vaccinated? If Yes to Vaccinated	___ Yes ___ No Doses 1 2 ___ Moderna ___ Pfizer ___ J & J	Have you received any form of the COVID-19 Vaccine
First Test?	___ Yes ___ No ___ Unknown	Is the patient being tested for COVID-19 for the first time?
Known Exposure?	___ Yes ___ No ___ Unknown	Has the patient been notified of being around a known COVID-19 outbreak?
Employed in Healthcare?	___ Yes ___ No ___ Unknown	Clinicians, Clinic/Hospital Staff, First Responders, Caregivers, etc.
Symptomatic as defined by the CDC?	___ Yes ___ No ___ Unknown If yes, check all the symptoms that apply in the next box.	CDC Symptoms (Check all that apply): Fever/chills ""cough shortness of breath fatigue muscle/body aches headache new loss of taste or smell ""congestion/runny
Onset date of symptoms:	Date: _____	nose, sore throat, nausea/vomiting, diarrhea.
Hospitalized?	___ Yes ___ No ___ Unknown	Is this patient currently admitted to a hospital?
ICU?	___ Yes ___ No ___ Unknown	Is this patient currently admitted to an ICU?
Resident in a congregate care setting?	___ Yes ___ No ___ Unknown	Including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting.
Pregnant?	___ Yes ___ No ___ Unknown	
Pre-Procedure/Pre-Operation?	___ Yes ___ No ___ Unknown	Is this patient scheduled for a procedure/operation in the near future?
Date of procedure/operation:	Date: _____	
<p style="text-align: center;"><u>Patient Consent / Authorization</u></p> <p>I hereby authorize the release of medical information related to this service of submission of personalized reports to my healthcare providers, insurance carriers, and Florida Department of Health. This information provided on this form is accurate. I hereby assign to the laboratory my right to insurance benefits that maybe payable to me for the services provided arising from any insurance policy, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of benefits directly to the laboratory. I understand acceptance of insurance does not relieve me from any responsibility for all charges whether or not they are covered by my insurance.</p>		<p style="text-align: center;"><u>Insurance / Payment Info.</u></p> <p>Primary Insurance Name: _____ Subscriber Name: _____ DOB _____ Policy #: _____ Subscriber Relationship _____ Secondary Insurance Name: _____ Subscriber Name: _____ DOB _____ Policy #: _____ Subscriber Relationship _____</p>
Patient / Parent / Guardian:		Date: