COVID-19 TESTING REGISTRATION FORM

Date of Service:_____ Time of Service:_____ Staff Initials: _____

PATIENT'S LEGAL NAME:		DATE OF BIRTH:
SEX: ☐ M ☐ F ☐ U	MARITAL STATUS: ☐ M ☐ S ☐ W ☐ D ☐ LP	
RACE: ☐ AA ☐ AI ☐ AS ☐ CA ☐ HI ☐ LA ☐ NA ☐ NH ☐ DECLINED ☐ OTHER		
ETHINICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ DECLINED		
PREFERRED LANGUAGE: ☐ English ☐ Chinese ☐ French ☐ Greek ☐ Indonesian ☐ Italian ☐ Japanese Korean ☐ Laotian ☐ Polish ☐ Portuguese ☐ Russian ☐ American Sign Language ☐ Spanish ☐ Vietnamese ☐ Other		
HOME ADDRESS:		
TOWN:	STATE:	ZIP CODE:
BEST CONTACT NUMBER:		
MAILING ADDRESS IF DIFFERENT FROM ABOVE:		
INSURANCE COMPANY NAME:		
INSURANCE CLAIM ADDRESS:		
INSURANCE TELEPHONE NUMBER:		
POLICY NUMBER:	SUBSCRIBER'S NAME:	SUBSCRIBER'S DATE OF BIRTH:
SECONDARY INSURANCE COMPANY NAME: If Applicable:		
SECONDARY INSURANCE CLAIM ADDRESS:		
SECONDARY INSURANCE TELEPHONE NUMBER:		
POLICY NUMBER:	SUBSCRIBER'S NAME:	SUBSCRIBER'S DATE OF BIRTH:
PRIMARY CARE PHYSICIAN/PRACTITIONER:	ORDERING (Attending) PHYSICIAN/PRACTITIONER:	

******MEDICARE PATIENTS ONLY******

Is Medicare eligibility based on: ☐ ***Age*** ☐ ***Disability or*** ☐ ***End Stage Renal Disease?***

Is Patient currently employed? ☐ ***Yes*** ☐ ***No***	***Is Spouse currently employed?*** ☐ ***Yes*** ☐ ***No***
If no, date of retirement:	***If no, date of retirement:***
If yes, name/address of employer:	***If yes, name/address of employer:***

Does patient have a group health insurance through his/her employer, or through spouse's employer? ☐ ***Yes*** ☐ ***No***

If on MCAB due to <u>AGE</u>: Does employer covering patient with a group health plan employ more than 20 employees? ☐ ***Yes*** ☐ ***No***

If on MCAB due to <u>DIS OR ESRD</u>: Does employer covering patient with a group health plan employ more than 100 employees?
☐ ***Yes*** ☐ ***No***

PLACE THIS FORM INSIDE SPECIMEN BAG AND DELIVER TO THE LAB