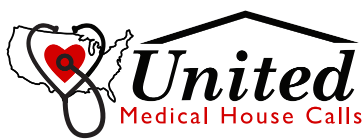

COVID TEST FORM

PATIENT INFORMATION

Name:_______________________________________

Street:_______________________________________

Town/State/Zip:________________________________

____

Phone:_______________________________________

Email:_______________________________________

Date of Birth________/________/_________

Sex (circle): M F

Soc Security #:_____________________________

INSURANCE INFORMATION

Insurance Company:___________________________

Claim Address:_______________________________

City/state/Zip:__________________________________

Group #:_______________________________________

Policy/ ID# :____________________________________

Name on Card:_________________________________

Date of Birth:___________________________________

Soc Security #:_________________________________

Effective Date:__________________________________

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19? **If yes,** what was the date? ____________________	☐	☐
Have you tested positive for COVID-19? **If yes,** what date did you test positive? ____________________________	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
If you have COVID-19, how long have you been free of symptoms?	Provide Date:___________	
Have you traveled outside the United States by air or cruise ship in the past 14 days?	☐	☐
Have you traveled within the United States by air, bus or train within the past 14 days?	☐	☐

Which test are you here for today? (Circle) PRC Antibody

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

Patient / Legal Guardian Signature____ Date:________________