Circle Testing Number							
1	2	3	4	5	6		
7	8	9	10	11	12		
13	14	15	16	17	18	19	20

COVID 19 Testing Registration Form

Patients temperature ________________

Present Symptoms ____

Demographic information

Name and Demographics	**First**		**Last**		
	Date of Birth		**Age**	**Gender** ( ) Male ( ) Female	**Social Security #**
Address	**Street**				**Apt #**
	City		**State**		**Zip Code**
Phone Number	**Home**		**Cell**		**May we leave a Message?** ( ) yes ( ) no
Marital Status (check one)	**Single ( ) Married ( ) Divorced ( ) Widowed ( ) Other ( )** __________________				
Primary Language	**( ) English ( ) Spanish ( ) French ( ) Other** _______________________				
Hispanic Ethnicity	**( ) Non-Hispanic ( ) Hispanic ( ) Puerto Rican ( ) Mexican ( ) Cuban** **( ) Other** ________________				
Race	**( ) African/African American** **( ) Native American or Native Alaska** **( ) Native Hawaiian** **( ) Other**_______________________			**( ) Asian/Asian American** **( ) White/Caucasian** **( ) Pacific Islander**	
Insurance	**Carrier**		**Policy#**		**Group#**
Sliding Fee Scale	**Family Size:**	**Annual Income:**	**Hours worked:**		**Hourly Pay:**
Emergency Contact	**Name:**		**Relationship:**		**Phone Number:**