COVID-19 Testing Consent Form

Name: _____ **Date of Birth:**_____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Sex:** Male Female

Make & Model of vehicle you will be arriving in: _____

Primary medical insurance (*please select one*):

☐ Idaho Medicaid
☐ Regence
☐ Blue Cross of Idaho
☐ Select Health
☐ Pacific Source
☐ Other primary insurance: _____
Group #: _____
ID #: _____
Billing phone number: _____
☐ No insurance

Were you exposed to COVID-19: ☐ No ☐ Yes If Yes, did you experience direct exposure to a COVID-19 positive person (*e.g., someone who lives with you*)? ☐ No ☐ Yes ☐ Unsure. Approximately how many days ago were you exposed to COVID-19? _____

What symptoms are you experiencing now? *Please select all that apply.*

☐ Fever or chills
☐ Cough
☐ Fatigue
☐ Muscle or body aches (i.e., myalgia)
☐ Headache
☐ Congestion or runny nose
☐ Sore throat/Hoarseness
☐ New loss of taste or smell
☐ Nausea or vomiting
☐ Diarrhea
☐ Shortness of breath or difficulty breathing
Mild Moderate Severe

☐ **No symptoms**

For how many days have you been experiencing symptoms? _____

Patient signature: _____ **Date:** _____

Symptoms of Coronavirus accessed from CDC website on September 16, 2020, available at https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html