MAHEC Mobile COVID Clinic Intake Form

Name ______________________________ **Race**__________ **Ethnicity**____________

DOB _____________ **Age** _________ **Sex** ______ **Cell #** ______________________

Address____

Insured Yes ☐ No ☐ **Insurance Company**______________________________

Group #______________ **Policy Holder's Name & DOB** ______________________

Subscriber ID# _____________ **Claims Address** ____________________________

Have you had any of the following symptoms listed below? Yes ☐ No ☐
If you answered yes, please mark symptoms with "X"

Fever ☐ temp______ Chills ☐ Loss of taste/ Loss of smell (circle); ☐ New Cough ☐ Dry or Wet; SOB ☐

Wheezing ☐ Runny nose/Congestion ☐ Sore throat ☐ Fatigue ☐ Muscle Aches ☐

New/Atypical Headache ☐ Nausea/Vomiting ☐ Diarrhea ☐

Chest Pain ☐ Dizziness ☐ Confusion ☐

Date Symptoms Started ________________

Have you been exposed to someone with COVID-19?

Yes ☐ Date:______________; NO ☐

Preferred phone number to call with COVID results:

Phone______________________________

Permission to leave a voicemail with COVID results at the number provided above: **Yes** ☐ **NO** ☐

Permission to give COVID results to **OTHER PERSONS** at the number provided above. **Yes** ☐ **NO** ☐

If YES, who? ____

Signature_______________________________ **Date**_____________________

Office Use Only below this line ______________________________________

Notes:

Testing and Plan: COVID: PML ☐ LabCorp ☐