URGENT CARE OF LONGWOOD

COVID-19 Testing
UNINSURED REGISTRATION FORM

Date: _____

Name: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ SSN: _____

Driver's License Number: _____ State Issued: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

LAST DATE TESTED FOR COVID-19 _____ RESULTS: ☐ Positive ☐ Negative

Have you been vaccinated? ☐ Yes ☐ No Date _____

Do you currently have or recently had? ☐Fever/Chills ☐Cough ☐Shortness of breath or difficulty breathing ☐fatigue ☐Muscle or Body aches ☐Headache ☐New loss of taste or smell ☐Sore throat ☐Congestion or running nose ☐Nausea or vomiting ☐Diarrhea ☐ **EXPOSURE TO COVID-19**

_____ I HEREBY Authorize Longwood Medical Group, dba Urgent Care of Longwood to release any information required to process my claim. I do not have any type of health insurance. If the claim is not paid, I will be responsible for $150 to Urgent Care of Longwood. By signing below, you agree that the information provided is accurate and also give permission to Urgent Care Center of Longwood to treat you.

_____Below for Office Use Only_____

I was tested for COVID-19 with a Rapid Antigen Test Cassette and the results was:

☐ Positive Test performed by: _____

☐ Negative Test performed by: _____

☐ A Nasopharyngeal specimen was collected, sent to Patients Choice Lab, Vista Lab, AVERO Lab, or Quest Diagnostic Laboratory for confirmation testing and I was given the information to go online to obtain my results.

☐ I declined nasal/oral swab testing

I have been advised to self-quarantine for 10 days and follow up for re-testing.

Patient Signature: _____ Date: _____