COVID TEST VISIT (ALL FIELDS ARE REQUIRED!!)

PLEASE WRITE NEATLY TO ENSURE YOU GET RESULTS!!!

Patient LEGAL Name:_____ **Pt DOB:** _____
(FIRST) (LAST)

Pt Sex: M or F **Cell Phone Number:** _____ **SSN#:** _____

Address: _____ **City:**_____ **State:**_____ **Zip:**_____

Patient email (required to get hard copy of results)**:**_____

Vehicle you arrived in (make, model, color):_____

Insurance: _____ **Member ID:**_____ **Group:** _____

SYMPTOMS (PLEASE CIRCLE ALL THAT APPLY): NONE COUGH SHORTNESS OF BREATH CHEST TIGHTNESS

RAPID BREATHING WHEEZING DIFFICULTY BREATHING FEVER WITHIN 14 DAYS

BODY ACHES HEADACHES DIARRHEA/VOMITING BEEN EXPOSED TO COVID19

MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY): NONE ASTHMA/COPD SMOKER/VAPE

DIABETES HIGH BLOOD PRESSURE IMMUNOCOMPROMISED

Genesis Medical Group Credit Card Authorization Form for SELFPAY

Please complete all fields.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy):_____ CCV: _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____ authorize Genesis Medical Group to charge my credit card above for agreed upon purchases in the amount of $125. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer Signature Date

I (patient), give permission to release results to (Name/Employer):_____

_____ _____
Patient Signature Date

I, patient, give consent to text and/or email my results to the email and/or cell phone number provided above.

_____ _____
Patient Signature Date