

# Demographic Information

**REGISTRATION**

Full Name: Last First MI

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apartment/Unit#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Main Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race:

American Indian/Alaska Native Asian

Black/African American

Native Hawaiian/Other Paciﬁc Islander White

Other

Prefer not to answer

Ethnicity:

Hispanic or Latino

Not Hispanic or Latino Prefer not to answer

Gender:

Female Male

Other (specify)

Do you consider yourself to be?

Heterosexual or straight Homosexual

Bisexual

Prefer not to answer

Primary Language: English Spanish

Other (specify) Insurance Information:

Name and ID # of Insurance

How many people live in your household?

Uninsured

# Current Symptoms

Are you currently having symptoms of Covid-19? (select all that apply)

No

Fever or chills Cough

Shortness of breath / diﬃculty breathing Muscle / body aches

Pneumonia Bronchitis Runny nose

Loss of taste/smell Sore throat Nausea

Vomiting Diarrhea Chest pain

Abdominal pain

Other (specify)

# Medical History

For females only--Are you currently pregnant? Yes No

Do you have the following risk factors? (select all that apply) 65 or older

Diabetes

Asthma COPD

History of stroke History of heart attack High blood pressure Cardiac condition HIV/AIDS

Chronic kidney disease Liver disease

Cancer or leukemia/multiple myeloma Smoker

Obesity

Have you ever been told that you have coronavirus-19?

Yes No If yes, when

# Awareness

How did you learn about the testing program?

From the internet From the radio From a Flyer Word of mouth

From a healthcare provider

# Release and Signature

I certify that my answers are true and complete to the best of my knowledge. I understand that I will be scheduled for a telehealth appointment within 5 days for my results.

Signature: Date:

Print Name: Emergency Contact Name: Emergency Contact Number:

I agree that my test results can be released for the purpose of informing me about the results.

Yes No

**CONSENT FOR MEDICAL SERVICES**

**I hereby consent to receive medical services from Aunt Martha’s Center**. I understand that I may revoke my consent in writing at any time. I also understand that any information regarding my medical history or treatment will remain confidential unless disclosure is required under existing state and federal laws. I consent to the release of my medical history and care to Medicaid, Medicare, insurance companies. Reviewing and Accreditation organizations and other Aunt Martha’s programs.

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Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian/Representative Signature Date

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Staff Witness Signature Date