Version 3

Community Health Center, Inc.

COVID Testing Registration

Section 1: All Patients Complete Section

I understand I can review CHC's Notice of Privacy Practices online at: https://www.chc1.com/privacy-statement

Date:_____

Receive results Fast via Text!

☐ **I consent to being tested for COVID**

☐ **I consent to receive text messages about my care (including results)**

☐ **I consent to receive negative results by voicemail on my ☐ mobile phone ☐ home phone ☐ both**

Mobile Phone #:_____ **Signature:**_____

Patient First Name:_____ Patient Last Name:_____

Preferred Name:_____ Date of Birth (mm/dd/yy):_____

Address:_____

City/State/Zip Code:_____

Home Phone:_____ Email:_____

Are you experiencing any symptoms? ☐ yes ☐ no

If yes, do you have Medicare or Medicare Advantage Plans? ☐ yes ☐ no

If yes, please provide your Medicare ID:_____

Section 2: New Patients ONLY Complete Sections 2 & 3

Sex ☐ Male ☐ Female ☐ Other

Race
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian ☐ White
☐ Native Hawaiian or Other Islander
☐ Declined ☐ Unspecified
☐ Other _____

Ethnicity
☐ Hispanic or Latino
☐ Non Hispanic or Latino
☐ Declined
☐ Unspecified
☐ Other _____

Section 3: Parent/Guardian Information

First Name:_____ Last Name:_____

Home Phone:_____ Email:_____

Date of Birth (mm/dd/yy):_____ ☐ Address same as above

Address: _____

City/State/Zip Code:_____

Parent or Guardian Signature:_____