(Insert Practice Logo)

COVID-19 Testing Intake Form

Patient Name: _____ Patient DOB:

Patient Address: _____ Patient Phone:

Patient Email:_____ Insurance plan/policy #:

CLINICAL HISTORY:

COVID Symptom(s) Onset Date: _____

Fever ❑ Yes ❑ No Cough ❑ Yes ❑ No Shortness of Breath ❑ Yes ❑ No

If Fever = YES, Temp: _____

Symptoms: _____

Comorbid Conditions: ❑None ❑Unknown ❑Pregnancy ❑Diabetes ❑ Cardiac Dz ❑Hypertension ❑Chronic Lung Dz ❑Chronic Kidney Dz ❑Chronic Liver Dz ❑Immunocompromised ❑Other, specify

_____

TRAVEL / EXPOSURE HISTORY:

Had contact with: Known or suspected patient with COVID-19? ❑ Yes ❑ No ❑ Unknown

Travel dates / Locations: Date/s: _____ From: _____ to: _____

Date/s: _____ From: _____ to: _____

Date/s: _____ From: _____ to: _____

Date/s: _____ From: _____ to: _____

Occupation: _____ Country of Residence: ❑ USA ❑ Other (specify):

_____

Current living situation: ❑House ❑Apt ❑SRO ❑Dorm ❑Homeless ❑Other _____

Do others Live in Household? ❑ Yes ❑ No If Yes, describe: _____

(Insert Practice Logo)

COVID-19 Consent Form

I authorize a nasopharyngeal swab for COVID-19 Test as either personally requested, ordered by my dentist or authorized physician provider. I further understand, agree, certify, and authorize the following:

1. I am the parent or legal guardian (if the patient is a minor or dependent) of the patient named above.
2. The (insert practice name) has contracted with Quest Laboratories for laboratory analysis and report of my, my child's, or dependent's specimen. I authorize Quest Laboratories to perform testing on my specimen.
3. I understand that processing of the specimen and results may take between 3 to 4 days.
4. The (insert practice name) **will release the results of my test only to the dentist or authorized physician who requested testing**. Results may be available for viewing by me at the Quest Laboratories Patient Portal. I authorize Quest Laboratories and/or (insert practice name) to release test results or other information necessary to the local and state departments to process said release of test results.
5. I understand that the dentist or authorized healthcare provider identified in this online application will be responsible for providing testing results, interpreting test results, explaining testing limitations, and providing any additional diagnostic or clinical services.

By signing below, I acknowledge that I have read, understand, agree, certify, and/or authorize the information above and further agree to hold harmless the (insert practice name), Quest Laboratories, including its team members, agents, and contractors from any and all liability and claims.

Signature: _____ Date: _____