NO ID:____ NOT INSURED:____

KOHALA COAST URGENT CARE, LLC
62-100 KAUNAOA DR, KAMUELA, HI 96743
PH (808)880-3211 FAX (808)475-0061

GROUP ID:	DATE:

NEW ____ ESTABLISHED ____ EMPLOYEE ____ RESIDENT ____ STUDENT ____

First Name: ________________________________ **MI**:____ **Last Name**:________________________________

Date of Birth: ________________________ **SSN**: _______________________ **Gender**: **Male**____ **Female**____

Mailing Address: ____ **Apt #**:______________

City: ____________________________________ **State**: ________ **Zip**:________________

Phone: ______________________________ **DRIVER'S LICENSE/STATE ID #**: ____________________________

Race: Am Indian/Alaskan Native Native Hawaiian/Pacific Islander Asian Black/African American White Multiple/Other

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Do you live in a: House / Apartment / Multi-generational Home / Unsheltered

****INSURANCE INFORMATION** [*PLEASE PROVIDE YOUR SSN# IF YOU ARE NOT INSURED*]**

Primary Carrier: ______________________________ **Subscriber #**: ____________________________________

Secondary Carrier: ____________________________ **Subscriber #**: ____________________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Kohala Coast Urgent Care, LLC or insurance company to release any information required to process my claims. I also consent medical treatment from Kohala Coast Urgent Care, LLC.

SIGNATURE: ____ **DATE**:______________________

_____ **(Initial) I authorize release of information in regard to COVID19 testing listed below:**

TEMP: ______>99

O2: __________

PULSE: ______>100

LAB: ORDER NASOPHARYNGEAL ____
LAB: ORDER NASAL ____

CLINICAL LABS-(COV19P-4142)
DX: Z20.822: Encounter for observation for suspected exposure to other biological agents ruled out (Possible exposure to covid-19)

KCUC: ORDER RAPID PCR TEST : ____
RESULTS: POSITIVE / Negative

KCUC:
ORDER RAPID AG TEST : ____

RESULTS: NEGATIVE / POSITIVE

LAB:

CC: RESULTS TO PATIENT EMAIL

#42224 KAOHIMANU AKIONA MD

ALL QUESTIONS MUST BE ANSWERED TO THE BEST OF YOUR KNOWLEDGE.

1. Have you been tested before (first test)? Yes / No If yes, when? ________________ Results: Negative / Positive
2. Are you employed in healthcare? Yes / No
3. Do you have symptoms as defined by CDC? Yes / No If Yes, when did your symptoms start? ____________
4. Have you been hospitalized for COVID-19? Yes / No
5. Have you been in ICU for COVID-19? Yes / No
6. Are you a resident in congregate care setting? Yes / No
7. Are you pregnant? Yes / No

8. Have **you tested positive**, or have a **close family member or contact who has tested positive**? Yes / No If Yes, please explain:

9. Are you concerned that you may have been **exposed to covid-19**? Yes / No If Yes, please explain:

10. Have you been in public gatherings with close contacts and not socially distanced? Yes / No

11. Work or have worked recently in high contact with the public? Yes / No

12. Have frequent exposure to at risk individuals or groups including those over 65, anyone with cancer or a weakened immune system, or live in a large multi-generational household? Yes / No

DO YOU HAVE SYMPTOMS AS DEFINED BY CDC? YES / NO **IF YES WHEN DID YOUR SYMPTOMS START?:** _________________
CIRCLE YOUR SYMPTOM(S): NO SYMPTOMS / SHORTNESS OF BREATH / DIFFICULTY BREATHING / CHEST HEAVINESS / COUGH / NAUSEA / VOMITING / LAST DAY OF FEVER:______________ & RECORDED FEVER _______________ / CHILLS / REPEATED SHAKING WITH CHILLS / DIARRHEA / HEADACHE / SORE THROAT / CONGESTION / RUNNY NOSE / LOSS OF TASTE / LOSS OF SMELL / MUSCLE PAIN AND JOINT ACHES / FATIGUE / RED EYES / RASH / OTHER: _________________

ANY RECENT TRAVELS? YES / NO **WHERE?** ______________________________ **TRAVEL DATES:** __________________________

DO YOU HAVE THE FOLLOWING HEALTH CONDITION? *(PLEASE CIRCLE IF APPLICABLE OR CIRCLE "NONE")*****

DIABETES MELLITUS / HIGH BLOOD PRESSURE / CANCER: TYPE_______________________ / COPD / ASTHMA / HEART DISEASE / OTHER: ____ / NONE

COVID POSITIVE; FAMILY OR CLOSE CONTACT WITH COVID POSITIVE

WHERE AND WHEN DO YOU THINK YOU CONTRACTED THE INFECTION? ____

ANY TRAVEL HISTORY? YES / NO **(IF SO, WHEN AND WHERE:** ____**)**

WORK HISTORY: ____

DID YOU QUARANTINE? YES / NO

INDIVIDUALS WITH RESPIRATORY ILLNESS FROM LATE DECEMBER THROUGH CURRENT

HAVE YOU SEEN A MEDICAL PROVIDER FOR YOUR SYMPTOMS? YES / NO **WHEN DID YOU HAVE SYMPTOMS?** _________________________

WHAT WAS YOUR DIAGNOSIS? ____ **WERE YOU TREATED? YES / NO**

WERE YOU TESTED FOR THE FLU OR STREP? YES / NO **IF YES, PLEASE CIRCLE**: FLU OR STREP **RESULTS:** NEGATIVE / POSITIVE

SYMPTOMS YOU WERE TESTED AND SEEN FOR: ____

ESSENTIAL WORKER OR OTHER

PLACE OF EMPLOYMENT OR COMPANY: ____ **ARE YOU:** FULL-TIME OR PART-TIME

TO THE BEST OF YOUR KNOWLEDGE DO YOU HAVE CONTACT WITH COVID PATIENTS? YES / NO

WHAT IS YOUR POSITION THERE?____________________________________ **WHAT DEPARTMENT DO YOU WORK IN?** _______________

DO YOU WEAR ANY OF THE FOLLOWING WHILE AT WORK: MASK / FACE SHIELD / PPE GOWN / GLOVES / GOGGLES: **OTHER**: _____________