Metropolitan Allergy and Asthma, PC
34 Sycamore Ave. Suite 1A
Little Silver, NJ 07739
Phone: (732) 383-5554
Fax: (732) 383-5495

COVID-19 Registration Form

Name:____

DOB:____________________

Address:____

City:__________________________________

State:______________ Zip:________________

Home Number:___________________________

Cell Phone Number:_______________________

Email:____

Insurance Name:____

ID #____

Group #____

Primary Care Doctor:____

Any other offices you would like your results sent to:_____________________

____

Survey Questions For Testing

-Have you traveled Domestically or Internationally in the last 14-30 days?

☐ Yes ☐ No

-Have you been exposed to anyone with a confirmed positive test for COVID-19 or exposed to anyone who is under mandatory quarantine for possible COVID-19 exposure?

☐ Yes ☐ No

-Do you currently have any of the following symptoms:

☐ Cough or Shortness of Breath

☐ Headache

☐ GI symptoms such as diarrhea

☐ Fever of 100.4 degrees or greater

☐ Loss of smell or taste

☐ Muscle aches or pains

☐ Other:_________________________________

Current Medication List: ____

____

____

Medical History:____

____

____

Surgical History:____

____

____

Allergies to Medications:____

____

Family Medical History (Parents, Siblings, Children)

Cardiac:____

Cancer:____

Diabetes:____

Other:____