Drive-Through COVID-19 Testing Event

Patient Intake Form

SECTION ONE: Basic Information

You will receive COVID-19 testing regardless of immigration status.

Patient Name (Last, First):		Date of Birth (mm/dd/yyyy)	
Street Address	City	State	Zip Code
Phone Number (*with area code*)	How do you identify? ❏ Male ❏ Female ❏ Non-Binary ❏ Trans - male ❏ Trans - female ❏ Preference (*Please specify*) _____		
Race/Ethnicity	Preferred Language		

SECTION TWO: Insurance Information

Please fill out this section if you have insurance. Note that your insurance will not charge you for these services. ***You will still be tested for FREE if you don't have insurance.***

Insurance Name	Subscriber ID
Subscriber Name (*If different*)	Group #
Insurance Address	