Office Use Only:
EMR # ______________
PCR Send Out: __________
Patient Notified: __________
County Health Dept:
____
Exposure: Yes or No

Urgent Care & Family Practice

COVID-19 TEST REGISTRATION FORM

First Name: ______________________ Last Name: ________________________ DOB: ___/____/_____

Address: ____

Phone: ______________________________ Circle One: Cell/Home Email Address: ____________________

Race: ____________________ Ethnicity: ________________ Languages Spoken (circle one): English or Other

Circle One: Is this your first COVID-19 Test? Y or N

Are you a healthcare employee? Y or N

Are you symptomatic? Y or N

Date symptoms began: ___/____/_____

Symptoms: Circle all that apply.

- Fever/Chills
- Cough
- Shortness of Breath
- Fatigue
- Muscle/Body Aches
- Headaches
- Loss of Taste/Smell
- Sore Throat
- Congestion/Runny Nose
- Nausea/Vomiting
- Diarrhea

Are you in a Nursing Home or Group Home (circle one)? Y or N

If yes to above question, what type of Group/Nursing Home? ______________________________________

Are you pregnant (circle one)? Y or N