St. James Health and Wellness COVID-19

Screening Enrollment Form

CHECK ONE: ☐ HEAD OF HOUSEHOLD ☐ DEPENDENT ☐IDS ☐ VETERAN Date: _____

MISS/MRS./ MR. (circle one)

_____

First Last

ADDRESS: _____ **TELEPHONE:** _____

Number Street Apt. No. Area Code Number

_____

City State Zip Code

SEX: ____ M ____F **DATE OF BIRTH:** ____ /___ /____ **AGE:** _____ **RACE:** _____

Month Date Year

Social Security Number: _____

EMERGENCY CONTACT:

NAME: _____ **TELEPHONE:** _____

INSURANCE INFORMATION

MEDICARE:

Insured's Name: _____

Policy No: _____

MEDICAID:

Insured's Name: _____

Policy No: _____

PRIVATE INSURURACE:

Insured's Name: _____

Policy No: _____

I, _____, understands today's visit for COVID-19 testing evaluation only and no vital signs, such as blood pressure

Patient Name

or temperature, will be done. If I have other concerns I understand I should contact my provider after 2 weeks if a test is done, or schedule another appointment if a test is not done. **I also understand there may be a fee for this test.**

____ I hereby certify that I have no insurance coverage for this test

Signature: _____ _____ **Date:** _____