**COVID-19 TESTING PATIENT INTAKE FORM**

**PLEASE FILL IN WITH THE NAME OF THE STAFF MEMBER AT SACHEM CENTRAL TEACHERS ASSOCIATION. WRITE NEATLY PLEASE. ALL INFORMATION MUST BE COMPLETED.**

FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IF A STUDENT, HOMEROOM: \_\_\_ ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_ GENDER: \_\_\_\_\_\_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THIS A MOBILE NUMBER: YES / NO MAY HEALTHCARE LOGICS SEND TEXT MESSAGES AS NEEDED?: YES / NO

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT/LEGAL GUARDIAN:

FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_ CONTACT NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION (YOUR INSURANCE WILL BE BILLED FOR THE SERVICE):

NAME OF INSURANCE PROVIDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEMBER ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF POSSIBLE, PLEASE TAKE A PHOTO OR PHOTOCOPY CARD AND STAPLE IT HERE.



PRIMARY PHYSICIAN:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing, I agree with Healthcare Logics LLC and all efforts of COVID-19 testing at Sachem Central Teachers Association. I recognize that Healthcare Logics is responsible for testing only. All medication and procedure adjustments are the responsibility of the primary care physician. I agree to allow Healthcare Logics to share pertinent information with my primary care physician and Sachem Central Teachers Association as needed. I agree to allow representatives of Sachem Central Teachers Association to receive my/my child’s testing results conducted by Healthcare Logics.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For all minors 14 and under, a parent or legal guardian must sign this form.

**Healthcare Logics LLC (346) 309-1207 www.HealthcareLogics.com**