PERSONIC HEALTH CARE

STAFF USE ONLY

❑ WALK-IN: _____

❑ APPOINTMENT: _____

❑ PCR

❑ RAPID ANITGEN: _____

❑ BOTH

Patient Intake Form

(Fecha)
Today's Date _____/_____/_____

(Nombre Del Paciente) (Fecha de Nacimiento)
Patient's Full Name _____ Date of Birth _____/_____/_____

(Numero de Telefono)
Cell Phone _____*must be able to receive text message _____

(Correo Electrónico)
Email _____*required to access results via Patient Portal

If insurance card not present, then please enter in following information:

(Seguro Medico)
Insurance Name: _____ Member ID: _____ Group ID: _____

(Sintomas)
Symptoms:

❑ NONE ❑ Cough ❑ Headache ❑ Runny Nose ❑ Nausea Vomiting

❑ Fever/Chills ❑ Fatigue ❑ Loss of taste ❑ Loss of smell Other: _____

Duration of Symptoms(Check one): ❑ NONE ❑ 1-3 Days ❑ 3-7 Days ❑ Greater than 7 days

(Historico Medico)
Medical History:

❑ NONE ❑ Asthma ❑ COPD ❑ High blood pressure ❑ Diabetes ❑ High Cholesterol

❑ Hypothyroidism ❑ Smoker Other:

(Firma de Paciente)
Patient Signature: _____

(Llena lo Siguiente No Si Seguro Tiene Medico)

For Non-Insured: Complete Below ONLY if you do NOT have medical Insurance

I, _____ , attest that I am uninsured and /or do not have a government ID.

(Numero de Seguridad Social)
Social Security #_____-_____-_____

(Direccion) (Codigo Postal)
Address: _____ Zip Code: _____

I affirm that all information given on this attestation is true, complete, and accurate to the best of my knowledge. By signing this form, you are consenting for COVID-19 test. If you feel ill, you should seek medical attention as soon as possible. I consent to receive my results via text or email. I consent to allow my insurance to be billed in or out of the network. I attest that I either have symptoms of COVID-19, which include but are not limited to any of the following: fever, chills, feeling weak or tired, headache, cough, body aches, loss of smell or taste, or other physical symptoms concerning for COVID-19, or I may at some point possibly have been exposed to someone either with COVID-19 or exhibiting signs or symptoms of COVID-19.