Please Bring this Completed form to the Test Site.

Car Number:_____
Arrival Time: _____
Provider: _____

COVID Testing Registration Information

Information	Please type or print clearly
Patient's Last Name:	
Patient's First Name:	
Patient's Sex:	
SS#	
Home Address (Street, City, State, Zip Code):	
Phone Number:	
Email Address:	
Patient's DOB:	
Patient's Race:	
Patient's Ethnicity:	*Please circle Hispanic or Non-Hispanic*
Patient's Native Language:	
**Name of Medical Insurance:	
Insurance ID #:	
If the insurance plan is not in your name, please complete the items below	***If not applicable, please write n/a***
Insurance Guarantor's Last Name:	
Insurance Guarantor's First Name	
Insurance Guarantor's DOB	
Insurance Guarantor's Phone Number:	

*** If you do not have medical insurance, you will be asked to provide your Social Security Number when you arrive to the mobile test site.*