MARION GENERAL HOSPITAL MGH

PATIENT REGISTRATION INFO FOR DRIVE-THRU TESTING

SERVICE DATE: _____

Name: _____ DOB: _____ Last four (4) SSN: _____

Sex: M/F Phone #: _____ Email Address: _____

Mailing Address/City/St/Zip: _____

Person to Notify: _____

MGH Employee? ☐ No ☐ Yes Department: _____

INSURANCE INFORMATION:

Name of Insurance: _____

Policy/ID#: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

If Patient is under 18 years old: Parent or Guardian Name:_____

Parent/Guardian Address (if different than above): _____

Parent/Guardian Phone #: _____

Relationship to Patient: _____

CLINICAL INFORMATION: What is your usual state of health? Good Fair Poor

Age: _____ Known Exposure to COVID in the past 2 weeks: Y / N (15 min spent within 6 feet)

Have you tested positive for COVID-19 in the past month? Y / N

Have you completed the COVID vaccine series at least 2 weeks ago? Y/N

***Circle any symptoms you've had in the last 48 hours*:** Headache, nasal/sinus congestion or drainage, fever/chills, cough, short of breath, nausea, vomiting, diarrhea.

_____DO NOT WRITE BELOW THIS LINE: _____

Rapid Antigen Test Results: Positive / Negative COVID PCR? Yes/No Ref Lab or In-House