



Document: COVID-19 Coronavirus Testing Request Form - #11242

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Submitted By: Dr. Ala Stanford

Q1. Last Name, First Name:

Smithy, Jan

Q2. Email:

jan@smith.com

Q3. R.E.A.L. will protect your information. Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between HHSN and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to verify your medical information is accurate and determine the type of medical supplies or health care services you need.

Yes, I Agree for R.E.A.L. to use my Information

No, I do not agree

Q4. Phone Number:

40453535

Q5. Age:

57

Q6. Date of Birth MM/DD/YYYY:

c y

Q7. Gender:

Female

Male

Prefer not to say

Q8. Do you have Health Insurance? Health Insurance IS NOT required, but if you have coverage we need to know.

Yes

No

Q9. If you answered "YES" above, please list: Health Insurance Company, Address, Policy Number, Phone Number:

Blue Cross Blue Shields - 4848484, 707-553-4567

Q10. Ethnicity:

Black

White

Hispanic

Asian

Other

Q11. When did your symptoms begin MM/DD/YYYY?

MM/DD/YYYY

Q12. Symptoms (check all that apply):

Cough

Shortness of Breath

Sneezing

Fever

Loss of Smell

Loss of Taste

Diarrhea

Tiredness or Fatigued

Sore Throat

None

Q13. Other Symptoms / More information about Symptoms

N/A



Q14. Have you been around someone who tested positive for coronavirus or thought to be positive?

Yes

No

Q15. If you answered "yes" above, who was the person (family member, co-worker, etc.)

Sister

Q16. Do you have other medical problems?

HTN

DM

Cancer

Kidney Disease

Auto Immune Disease

None

Q17. Any other other Medical Problems / More Information on Medical Problems:

N/A

Q18. DISCLAIMER: You agree and affirm that you will not hold REAL Concierge Medicine or Black Doctors COVID19 Consortium liable for any issues associated with your testing and or test results and subsequent treatment or care you receive from another facility or ambulance.

Yes

No

Q19. R.E.A.L. will protect your information. Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between HHSN and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to verify your medical information is accurate and determine the type of medical supplies or health care services you need.

Yes, I Agree for R.E.A.L to use my Information

No, I do not agree



Attachment(s)