Document: COVID-19 Coronavirus Testing Request Form - #11241

Date Recorded:4-23-2020 11:04:15
Submitted By: Dr. Ala Stanford

Q1. Last Name, First Name:
Smith, Gayle

Q2. Email:
smith@gayle2.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:
404-543-8300

Q5. Age:
26

Q6. Date of Birth MM/DD/YYYY:
03/24/2000

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

Q10. Ethnicity:
- ● Black
- ❍ White
- ❍ Hispanic
- ❍ Asian
- ❍ Other

Q11. When did your symptoms begin MM/DD/YYYY?
03/12/2010

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 Symptons
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.)
Bob

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 - Stuff

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)