

DATE: _____

Social Security #: _____

Demographics

Legal Last Name: _____ Legal First Name: _____ Middle Name/Initial: _____

Former Last Name(s): _____ Birth Date: _____ Birth Place: _____

Country of Residence: _____ Language: _____ Military: ☐ Active Duty ☐ Veteran ☐ N/A

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

County: _____ Home Phone: _____ Cell Phone: _____ Email: _____

Gender Assigned at Birth:

☐ Male ☐ Female

Gender Identity:

☐ Male ☐ Female

☐ Transgender Man

☐ Transgender Female

☐ Other: _____

☐ Decline to Answer

Race:

☐ American Indian/Alaska Native

☐ Asian ☐ Black/African American

☐ Native Hawaiian/Other Pacific

Islander ☐ White ☐ Other

Ethnicity:

☐ Hispanic/Latino

☐ Not Hispanic/Latino

Smokeless Tobacco:

Moist Powdered Tobacco/Snuff/Chew:

☐ Never ☐ Ex-User ☐ Current User

Smoking Status:

☐ Current Every Day Smoker

☐ Former Smoker ☐ Never Smoked

☐ Heavy Smoker ☐ Light Smoker

Tobacco Start Date: _____

Tobacco Stop Date: _____

Sexual Orientation:

☐ Lesbian/Gay/Homosexual

☐ Straight/Heterosexual

☐ Bisexual

☐ Something Else ☐ Don't Know

Marital Status:

☐ Single ☐ Married ☐ Divorced

☐ Separated ☐ Life Time Partner

☐ Widowed

Driver's License #: _____ State of License: _____ Occupation: _____

Employer's Name: _____ Employer's Phone: _____

Employer's Mailing Address: _____ City: _____ State: _____ Zip: _____

Employer's Physical Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Do you have an Advance Directive? ☐ Y ☐ N If YES, what type: _____

Emergency Contact's Name & Phone #: _____ Relation: _____

Billing Information/Primary Insurance

Person Financially Responsible for Charges (Guarantor): _____ Phone: _____

Guarantor's Mailing Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's Birth Date: _____ Relation: _____

Subscriber's Mailing Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Employment: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired (Date): _____ ☐ Active Military

Subscriber's Employer: _____ Employer's Phone: _____

Employer's Mailing Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance

Insurance Company: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's Birth Date: _____ Relation: _____

Subscriber's Mailing Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Employment: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired (Date): _____ ☐ Active Military

Subscriber's Employer: _____ Employer's Phone: _____

Employer's Mailing Address: _____ City: _____ State: _____ Zip: _____



SENECA HEALTHCARE DISTRICT

Informed Consent: COVID-19

This document is for reference purposes only. It is intended to provide general guidance, is not legal advice and is not a statement regarding any standard of care. This document does not take into account every law or requirement of federal, state or local authorities.

Please carefully read and sign the following Informed Consent:

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test.

I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a nasal, nasopharyngeal swab or blood draw, as ordered by an authorized medical provider or public health official. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by Federal, State or local laws. I acknowledge that a positive test result is an indication that I must self-isolate and or wear a mask or face covering as directed in an effort to avoid infecting others.

I understand the testing unit is not acting as my medical provider. This testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results.

I agree that I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I understand that I may receive a phone call from Seneca Healthcare District regarding my test results.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I will receive a copy of this Informed Consent upon request. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time.



SENECA HEALTHCARE DISTRICT

Informed Consent: COVID-19

I voluntarily agree to this testing for COVID-19.

By signing this form, you acknowledge that you understand the risks and benefits of receiving testing for COVID-19.

Your signature documents permission for you (or the patient) to receive COVID-19 testing.

Today's Date

Time:

AM/PM

Patient's Date of Birth

Legal First Name

Preferred First Name

Last Name

Printed Name of Patient _____

Signature of Patient or Legally Authorized Representative

PERSON OBTAINING CONSENT: I have explained the testing for COVID-19 to the patient/authorized legal representative and I have answered all questions to the best of my ability.

PATIENT LABEL

AUTH ON FILE

- ☐ NO
☐ YES

- AUTHORIZED PERSON(S) _____
- EXP: _____

REQUESTED:

DATE: _____

TIME: _____

Medical Records Request Form

In order to pick up any medical records you must present your ID and have an authorization and disclosure signed or sign one upon pick up. If you would like someone other than yourself to pick up these records you will have to sign an authorization and disclosure with the person's full legal name as it appears on their form of ID upon filling this form out. This person will need to present their ID upon picking your records up.

Note: Authorizations and disclosures are good for ONE year.

Please allow up to 14 days before your request is complete.

Last Name: _____ First Name: _____ M.I. _____

MR# _____ DOB: ____ / ____ / ____ Phone Number: _____

Records Requested? _____

Report **CD** Date(s) of Service: _____

Where are the records going? _____ Patient to Pick-up
 _____ Mail to Patient (must have a valid auth.)
 _____ Send to Provider: _____ Fax: _____
 _____ Other: _____

Records Needed Immediately? **YES** **NO** Appt Date: _____

If yes, please state why: _____

Additional comments / Special instructions: _____

****Office use only****

Employee Name and Department

PATIENT STICKER
(IF AVAILABLE)