EXPRESS MEDICAL EXPERTS

Patient Demographic Form

COVID-19 Test Performed		
☐ Antigen	☐ Rapid Antibody	☐ PCR
Collection Date:		
☐ Self-Pay	☐ Insurance	☐ Other

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:
Date of Birth:	Social Security Number:	Sex: ☐ Male ☐ Female
Race: ☐ Black-Non Hispanic ☐ American Indian/Alaskan Native ☐ Hispanic ☐ Asian/Pacific Islander ☐ White-Non Hispanic ☐ Other		
Home Address:		Apt #
City:	State:	Zip Code:
Email:		Phone:

PHYSICIAN REFERRAL INFORMATION

Clinic Name:	Phone:
Primary Care Physician:	Fax:

MEDICAL QUESTIONNAIRE

Is this your first COVID-19 test? ☐ Yes ☐ No	Have you ever tested Positive for COVID-19? ☐ Yes (Date: _____) ☐ No
Are you employed in healthcare? ☐ Yes ☐ No	
Symptomatic (illness) as defined by CDC? ☐ Yes (Date of onset: _____) ☐ No ☐ Unknown	
Known exposure to COVID-19 positive person? ☐ Yes (Date of exposure: _____) ☐ No ☐ Unknown	
Have you been hospitalized for COVID-19? ☐ Yes ☐ No ☐ Unknown	If Yes, were you treated in the ICU? ☐ Yes ☐ No
COVID-19 Vaccinated? ☐ Yes (Date: _____) ☐ No	Pregnant? ☐ Yes ☐ No ☐ Unknown

*If you are unable to provide copy of your insurance card, please complete the insurance information section below.

INSURANCE INFORMATION

Insurance Company:		Relationship to Insured:
Member ID:	Group:	Phone:

All patients - by signing the bottom of this form, you are confirming that you understand and agree to the following:

I agree that laboratory will furnish to my designated insurance carrier the information on this form necessary for reimbursement. I hereby authorize service be performed and assign those benefits be payable to laboratory. I understand that if any insurer does not pay and denies the claim as an uncovered service, I am responsible for payment. If my insurer pays me directly, I agree to endorse the check and forward it to the laboratory within 30 days. I understand that I am responsible for any amounts not to be paid by insurer for reasons including but not limited to, non-coverage and non-authorized services. I permit a copy of this authorization to be used in place of the original. I authorize my insurance benefits be paid directly to the laboratory for services I received. The laboratory is authorized to bill my insurance provider and to receive payment of benefits for the tests my physician orders. I further authorize the testing laboratory and my physician to release to my insurance provider any medical information necessary to this claim.

Patient Signature:	Date:

Digital copies of Photo ID or Insurance information can be sent to info@expressmedexperts.com.