Please complete all fields, PRINT, and bring to your appointment to speed up your visit.

Full Name:			
Date of Birth:	MM DD YYYY	Gender:	
Home Address:	Street City State ZIP		
Telephone			
Insurance Plan Name:			
Insurance Member ID:			
Ordering Provider: (who ordered this test)			
Ordering Provider Office:			
Ordering Provider Phone:			

Symptom Questionnaire:

Do you currently have any symptoms of COVID-19? Yes ☐ No ☐
(circle one)

If yes, when did your symptoms begin? _____ / _____ / _____
(write in date)

Consent:

The specimen identified on this form is my own. I have not adulterated the specimen in any way. I am voluntarily submitting this specimen for analysis by Lehigh Valley Genomics. I authorize the lab to release the results of this test to applicable departments of health and my primary care provider. Lehigh Valley Genomics is authorized to bill me to receive payment of benefits for this test and I agree to reimburse Lehigh Valley Genomics for any portion of the test not paid for by an insurance company or other means.

Patient Signature: _____ Date _____

Guardian Signature (if under 18 years of age): _____ Date _____

LAB USE ONLY:

PADC? Y N; Y – L4 _____