INFECTIOUS DISEASE
CARE CENTER

Imran Chowdhury, M.D.
Kody Modjtabai, M.D.
Imelda Russell, CRNP.

All Fields are required unless marked (Optional).

In the last 14 days, have you had contact with someone who has a suspected or confirmed case of covid-19?

☐ Yes ☐ No

Have you been asked or referred to get tested by a healthcare provider?

☐ Yes ☐ No

Have you experienced any symptoms in the last 14 days?

☐ Yes ☐ No

Are you currently pregnant? (Optional)

☐ Yes ☐ No ☐ Not Applicant

Is this test for travel purposes?

☐ Yes ☐ No

10816 Hickory Ridge Rd.
Columbia, MD 21044
Phone: 410-997-7677
Fax: 410-997-1636

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Suite 2500
Riverdale, MD 20737
Phone: 240-770-6345
Fax: 240-467-3993

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Do you have health insurance coverage? This includes private health insurance, Medicare plans and Medicaid plans.

☐ Yes ☐ No

If the test is positive, would you like to schedule a virtual visit with our Infectious Disease providers?

☐ Yes ☐ No

I acknowledge that I have answered these questions truthfully to the best of my knowledge.

Full Name	**Date of Birth**
Signature	**Today Date**

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PATIENT INFORMATION

If using insurance, please enter your as it appears on your insurance card

First Name:

Last Name:

Date of Birth:

Email:

Your relationship to the patient:

- ☐ I am the patient
- ☐ Parent of the patient
- ☐ Legal guardian of the patient
- ☐ Auth representative of the patient

Address:

Address:

City: **State:** **Zip Code:**

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The CDC requires us to collect this info to see how COVID-19 impacts our communities.

Gender: ☐ Male ☐ Female ☐ Prefer not to answer

Ethnicity:
- ☐ Hispanic or Latino
- ☐ I don't want to answer
- ☐ Not Hispanic or Latino
- ☐ I don't know

Race:
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Hispanic
- ☐ Asian
- ☐ White or Caucasian
- ☐ I don't want to answer
- ☐ I don't know
- ☐ Other

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Your contact information is only used for messages about this test. We'll call your mobile number when we have your results.

MOBILE NUMBER: ( ) -

CAN WE LEAVE VOICEMAIL IF NO ANSWER? ☐ Yes ☐ No

By giving your mobile number, you agree to receive calls about this and follow-up visits, test results, healthcare, account and insurance, and agree to the Terms of Use and Privacy Policy.

HEALTH INSURANCE

We bill your insurance or a federal program so that it's no cost to you.

Primary Insurance:

Subscriber Number:

Secondary Insurance:

Subscriber Number:

Third Insurance:

Subscriber Number:

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INFO ON COVID-19's HEALTH IMPACT

These questions help us fulfill our reporting requirements to the CDC and other state or federal agencies. They help us see the impact of COVID-19 on our health and the effectiveness of vaccines.

Do you work in healthcare? ☐ Yes ☐ No

Are you a resident in a special setting where the risk of COVID-19 transmission may be high? (Optional)

☐ Yes ☐ No

This may include long-term care, correctional and detention facilities; homeless shelters; assisted-living facilities and group homes?

☐ Yes ☐ No

Have you received a COVID-19 vaccine? ☐ Yes ☐ No

Leave a detailed voicemail with my results if I miss your call. ☐ Yes ☐ No

If YES, please provide the Facility Name(s), Phone Number(s) and Fax Number(s) below:

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Please write your initials to show that you agree with the following statements:

_____ I'm consenting to test for COVID-19 –voluntarily– and can decline any tests at any time.

_____ My test results will be reported to the state health department where required by law.

_____ A copy of the Notice of Privacy Practices has been made available to me.

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