Are you currently experiencing any Covid-19 symptoms? ☐ **None**

☐ **Headache**	☐ **Nausea**	☐ **Diarrhea**	☐ **Loss of taste or smell**	☐ **Chest tightness**	☐ **Muscle ache**	☐ **Fever**
☐ **Vomiting**	☐ **Cough**	☐ **Chills**	☐ **Shortness of Breath**	☐ **Nasal congestion**	☐ **Sore throat**	☐ **Other______**

Last Name: _______________________ First Name: _______________________________

Date of Birth: ____-___-_________ Male/Female (circle one) Height _______ Weight _______

Home Phone: (_____) ________________ Cell: (_____) _________________

Street Address: ____ Apt: _______

City: _______________________________ State: _________ Zip Code: ___________

Email: ____

Allergies to medications: ____________ Tobacco Use: **yes/no** Alcohol Use: **yes/no**

Insurance Provider: ______________________________________

Member ID: ____

Skip if you have the card with you

If no insurance, please provide SSN: ☐☐☐-☐☐☐-☐☐☐☐

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to MedRite Urgent Care medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize MedRite Urgent Care to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing. (4) Any outside medical facility requested by me. (5) Release any information necessary to my employer for services paid for by my employer. (6) Release my results to managing organization, if tested in group setting. I have requested medical services from MedRite Urgent Care on behalf of myself and/or my dependents, and the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I authorize you to use or disclose my health information in the manner described above.

Name: ___________________________ Signature: ________________________ Date: ___________

--OFFICE USE ONLY--

Temp _________ **Pulse _________** **SPO2 ________**

Test Type: ☐ **Rapid** ☐ **PCR**

Rapid Results: ☐ **Positive** ☐ **Negative**