Community Medical Providers
MEDICAL GROUP

2021 NOVEL CORONAVIRUS SCREENING QUESTIONNAIRE

INFORMATION

Name_____ Date of Birth_____ Date: _____
Last, First Middle MM/DD/YYYY MM/DD/YYYY

1. Is this for surgery? ☐ Yes ☐ No
2. First test? ☐ Yes ☐ No ☐ Not Given
3. Employed in Healthcare? ☐ Yes ☐ No
4. Symptomatic:
   - ☐ Fever/Chills
   - ☐ Cough
   - ☐ Shortness of Breath
   - ☐ Fatigue
   - ☐ Muscle/Body Aches
   - ☐ Headache
   - ☐ Sore Throat
   - ☐ New Loss of Taste/Smell
   - ☐ Congestion/Runny Nose
   - ☐ Nausea/Vomiting
   - ☐ Diarrhea
5. Date of Symptom Onset? _____/___/_____
6. Congregate Care Setting? ☐ Yes ☐ No ☐ Not Given
7. Pregnant? ☐ Yes ☐ No
8. Race? _____
9. Ethnicity? _____
10. Source: *Office Use*
    - ☐ Nasopharyngeal
    - ☐ Oropharyngeal
    - ☐ NP/OP
    - ☐ Bronchial Lavage/Wash
    - ☐ NP Aspirate/Wash
    - ☐ Mid Turbinate Aspirate
    - ☐ Anterior Nares
    - ☐ Not Given

Please call CMP Urgent Care at (559) 437-7304 for questions or to make an appointment.

Community Medical Providers
MEDICAL GROUP

URGENT CARE

PATIENT REGISTRATION

Date_____20___

PATIENT'S INFORMATION

Patient's Name (Last, First Middle) _____ Social Security # _____

Date of Birth_____ Age___ Sex ☐M ◯F Marital Status: ☐Single ◯Widowed ◯Divorced ◯Separate

Home Address_____ City _____ State _____Zip _____

Mailing Address_____ City _____ State _____Zip _____

Home Phone _____ Work _____ Cell _____

Consent to receive text messages and or messages for appointment reminders: ☐Yes ◯No

Employer _____ Occupation_____

Work Address _____ City _____ State _____Zip _____

Emergency Contact_____ Phone_____

RESPONSIBLE PARTY INFORMATION

Responsible Party (Last, First Middle) _____ Social Security # _____

Address: _____ City _____ State _____Zip _____

Employer _____ Occupation_____

Work Address _____ City _____ State _____Zip _____

Work Phone_____ Driver's License # _____

INSURANCE INFORMATION

Primary Insurance _____ Subs. Names _____

Company _____ Subs. DOB _____

Employer _____ Subs. I.D.# _____

Address _____ Group # _____

City _____State _____Zip _____ Subs. Date of Birth_____

Name of Primary Care Physician: _____ Name of Pharmacy _____

Please provide the receptionist with your insurance cards.

CONSENT

I hereby give consent for medical or surgical treatment to the attending physician to care for myself or I am duly authorized by the patient as his/her general agent to give consent of such treatment. I hereby give consent for release of medical information to consulting physicians and other medical personnel, as may be required in the rendering of treatment. I understand I am financially responsible for services rendered for the services rendered. In the event of collection action I shall be responsible for any legal fees incurred.

X _____ _____

Patient/Responsible Party Signature Date

ASSIGNMENT

I hereby authorize payment directly to the attending physician of any medical/surgical benefits payable to me under the conditions of my policy for serviced rendered. I hereby give consent for release to authorize person of financial and medical information concerning care, treatment and changes as may be required to complete all claims for benefits.

X _____ _____

Patient/Responsible Party Signature Date

How were you referred to our office? ☐ Mailer ◯ Brochure ◯ Friend ◯ Insurance ◯ Other _____

Whom may we thank for referring? _____

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800) 633-3322 www.mbc.ca.gov