COVID 19 Testing Patient Information Sheet

To ensure your safety testing is done by appointment only by calling 630-357-1030.

Thank you for choosing our office. In order to properly serve you please complete this form. Print your answers.
A physical exam is recommended for every child tested since COVID symptoms are similar to FLU, Strep Throat and common colds. Check here ❒ if you want your child examined and tested for other illnesses.

FINANCIAL DATA

Responsible Party's Name (**Last, First, Middle**) | Relationship to Patient | Birth Date

Current Mailing Address | City | State | Zip code | (**Area Code**) Home Telephone

Occupation | Social Security Number | Employer Name

Employer Address | City | State | Zip code | (**Area Code**) Work Telephone

PAYMENT INFORMATION

Do you have medical insurance? ❑Yes ❑ No If Yes, does your insurance company participate with us? ❑ Yes ❑ No
Please *note*: we are not able to file insurance claims to every company. As a pediatric office, we cannot accept Medicare. If not using insurance, our out of pocket charge for a COVID19 Rapid Antigen Test is $60 payable by cash or credit card at the time of service. Payment can be done over the phone or in person. Continue completing this part if using insurance.

Insurance Company Name | Policy Number | Group Number | Co-pay amount

Insurance Company Address | City | State | Zip code

Authorization to Submit Insurance Claims

1. I authorize this office to release any information necessary to process insurance claims.
2. I understand that I am responsible for all charges, regardless of insurance coverage.
3. I hereby assign payment of medical insurance benefits to Naperville Pediatric Associates.
4. I authorize the release of a copy of this authorization to be used in place of the original.
5. **I certify that the above information is correct.**

Signature | Date | Relation to Patient

Consent for Treatment

I consent to COVID 19 rapid antigen testing by swabbing my nostrils with a Dacron tip test swab performed by the attending physician or his/her assistant or designee as may be necessary in his/her best medical judgment.

Signature | Date | Relation to Patient

PATIENT DATA

Patient Name (**Last, First, Middle**) | Birth Date

Current Mailing Address if different from above | City | State | Zip code | (**Area Code**) Home Telephone

Sex (Circle One) | Race (Circle One) | Ethnicity (Circle One)

Male / Female/ Other | Asian /Indian American/ Black / Pacific Islander/ White / Other | Hispanic Non-Hispanic

Write the name and date of birth of any additional family members with the same address and insurance.

Time_____

Result _____