Please provide our office staff with either your Passport OR a photo ID

Patient Full Name: _____

Sex: _____ Date of Birth: _____

Home Address: _____
Apt # City State Zip

Cell Phone Number: _____ Email address: _____

Secondary Number(optional): _____ Secondary Email(optional): _____

Verbal Consent (anyone we are able to share your medical information with and/or give results to):

Name: _____ Date of Birth: _____ Relationship: _____
Name: _____ Date of Birth: _____ Relationship: _____
Name: _____ Date of Birth: _____ Relationship: _____

Flight Information, please provide incase there is an issue at the airport. The information requested is for any flights from Nashville, please only list this flight information. Thank you

Date of Flight: _____ Time of takeoff: _____

Airline: _____ Final Destination: _____

Have you been experiencing any symptoms of COVID? (i.e., cough, sore throat, fever, runny nose, etc)?
YES NO

Have you been exposed to anyone who is currently COVID+ that you know of?
YES NO

Have you had the COVID-19 vaccine?
YES NO If yes, please list the approximate date: _____

_____ _____
PATIENT'S SIGNATURE **DATE**