Mobile Dentistry of Arizona

Mobile: 480313-8000
Office: 480-313-3310
Fax: 480-772-4032
PatientCare@mobiledentistryofarizona.com

COVID-19 Testing: Patient Intake

Patient Name(Last,first): _____,_____

Date Of Birth: ____/____/_____ **Gender:** _____

Address: _____ **City:** _____ **State:** ____ **Zipcode:** _____

Phone Number: _____ **Email:**_____

Recent Symptoms, if any: _____

Type of test needed?

☐ **RAPID COVID-19 Antigen Test (nasopharyngeal swab)**
☐ **RAPID COVID-19 Antibody Test (finger stick)**

POA Name(Last,first): _____,_____

Phone Number: _____ **Email:**_____

Send Test Results To: ☐ **Employer** ☐ **POA** ☐ **Healthcare Provider** ☐ **Self**

Name: _____

Fax Number: _____ **Email:**_____

COVID-19 Testing: Informed Consent

Please carefully read and sign the following Informed Consent. By signing I further understand, agree, certify, and authorize the following:

1. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a nasopharyngeal swab or finger stick for the patient named above.

2. I authorize test results to be disclosed to the county, state, or to any other governmental entity as may be required by law. I authorize release of test results to listed employer, POA, or Healthcare Provider, upon request.

3. I acknowledge that a positive test result is an indication that I must self-isolate and/or wear a mask or face covering as directed in an effort to avoid infecting others.

4. I understand that this test does NOT rule out COVID-19 in ALL COVID-19 Patients. The possibility of a false negative result should be considered in the context of a recent exposures and the presence of clinical signs and symptoms consistent with COVID-19. If COVID-19 is still suspected based on exposure history together with other clinical findings, re-testing or testing with molecular methods should be considered.

5. I understand this test is for COVID-19 screening purposes ONLY. This screening event is NOT for Medical or life-threatening medical emergencies. This screening event is NOT intended for diagnosis, treatment, recommendation and/or management of ANY medical conditions. This screening event is NOT a substitute for a regular Company or Physician visit.

6. I agree to provide pre-payment or payment at the time of testing.

By signing below I acknowledge that I have read, understand, agree, certify, and/or authorize the information above and further agree to not hold Mobile Dentistry of Arizona, its employees, agents, and contractors from any and all liability and claims.

Patient or POA Name (please print): _____

Patient or POA Signature: _____**Date:**____/____/_____

For any questions on Mobile Dentistry of Arizona's policies and procedure please contact us 480-313-8000

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COVID-19 Testing: Results Form

Patient Name(Last,first): _____,_____

Date Of Birth: ____/____/_____

Send Test Results To: ☐ **Employer** ☐ **POA** ☐ **Healthcare Provider** ☐ **Self**

Name: _____

Fax Number: _____ **Email:**_____

For Office Use Only

RAPID COVID-19 Antigen Test

Test Date: ____/____/_____

RAPID COVID-19 Antigen Testing Start Time: _____ End Time: _____

Performed By: _____

RAPID COVID-19 Antigen Test Results	**POSITIVE**	**NEGATIVE**

RAPID COVID-19 Antibody Test

Test Date: ____/____/_____

RAPID COVID-19 Antibody Testing Start Time: _____ End Time: _____

Performed By: _____

RAPID COVID-19 Antibody Test Results	**POSITIVE**	**NEGATIVE**