ABBEVILLE AREA MEDICAL CENTER

Smaller. Smarter. Safer.

PLEASE PRINT

First Name	**Last Name**	**Middle Initial**
Mailing Address		
City	**State**	**Zip Code**
Telephone ( )	**Age**: _____ **Birthdate**: _____	**Circle One**: **Male** **Female**
Employer: _____		**Ethnicity**: Hispanic/Latino Non-Hispanic/ Latino
Race: White Black/African American Asian Native Hawaiian/Pacific Islander American Indian		

I hereby authorize Abbeville Area Medical Center staff (and whomever they delegate) to provide medical, Telehealth, emergency and in-patient care of such treatment that may include/but is not limited to health screening, diagnoses, medical treatment, social services, and/or mental health & drug & alcohol screening, assessment, diagnoses, and treatment as is found necessary. I also authorize the release of any medical information necessary to process claims and promote continuity of care with other healthcare and enabling services.

Patient: _____ **Date**: _____

COVID SCREENING (This will be completed onsite- Office Use Only)

Have you been in contact with someone who was confirmed or suspected to have Coronavirus/COVID-19?

YES No/Unsure

Have you traveled internationally in the last month? Yes No/Unsure

Do you have any of the following symptoms?

None	Unable to assess	Abdominal Pain	Bruising or Bleeding
Cough	Diarrhea	Weakness	Joint Pain
Muscle Pain	Rash	Red Eye	Severe Headache
Shortness of Breath	Vomiting	Fever	

Screener's Signature: _____

Tester's Signature: _____