PRE-REGISTRATION FORM

Beebe Healthcare
MEDICAL GROUP

Instructions: Please fill out, print, and sign this form prior to coming to the Testing Event. The form will be collected at the event.

Name: _____
DOB: _____
Address: _____
Phone #: _____
Gender: _____
Race: _____
Ethnicity: _____
Employer: _____
Your Primary Care Physician: _____

If you do not have a Primary Care Physician, would you like us to contact you to schedule an appointment with one? ____Yes ____No

Do you work in a restaurant? ____Yes ____No

Are you a United States Veteran? ____Yes ____No

If yes, would you like to be contacted by the Veterans Association (VA) with more information regarding healthcare options? ____Yes ____No

AUTHORIZATION TO TREAT

Permission is hereby granted to all healthcare providers involved in my care to administer such examination, treatment, testing and procedures that are deemed necessary in the course of my care. I have read and understand the policy and agree to abide by its guidelines:

_____ ___/___/___
Patient Signature **Date**

_____ ___/___/___
Patient Name (Print) **Date of Birth**

If you have questions, please call Beebe Medical Group's Coronavirus Screening Line at 302-645-3200. Thank you for the privilege of caring for you!