DRIVE-THRU COVID TESTING

Last Name: ____________________ First Name: ____________________ MI: __________

Date of Birth: ____________________ Male ☐ Female ☐

Phone Number: ____

Email: ____

Address: ____

Subscriber Name: ____________________ Subscriber DOB: ____________________

By completing this document, I give my consent to treat.
By completing this document, I agree to pay unpaid insurance balances including collection fee.

OFFICE USE ONLY

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