DOTHAN PEDIATRIC Healthcare Network
Dothan · Eufaula · Enterprise · Ozark

Please complete this form and return to patient representative at the desk. Then, wait in your car until a nurse calls for you to enter the building. Thank you for your understanding as we work to keep you and our staff healthy and well.

Date of Birth _____ **Patient Name** _____

What phone number can we call while you are here?

Which provider are you seeing today?

REASON FOR VISIT

☐ Check-up, Age _____ ☐ Sick ☐ Vaccine Only ☐ Lab Only

☐ Other: _____

Symptoms?

FEVER, **in the past 24 hours**? ☐ YES ☐ NO

COUGH? ☐ YES ☐ NO

SHORTNESS OF BREATH? ☐ YES ☐ NO

HAS PATIENT HAD DIRECT CONTACT WITH SOMEONE WHO HAS RECEIVED A CONFIRMED POSITIVE CORONAVIRUS TEST? ☐ YES ☐ NO

OFFICE USE ONLY
STAR, IF KNOWN EXPOSURE!!!!!

By signing below, I agree to:

- Consent for medically necessary treatment by the providers of Dothan Pediatric Healthcare Network.
- Authorize any medical information about the patient to be released to the Health Care Financing Administration and to my insurance company, if needed to determine these benefits or the benefits payable for related services.
- Be responsible for services not covered by my insurance carrier.

Signature Date