Dr. Robin Arora, M.D., M.B.A

Clinic Visit _____ Date _____

Rapid Only: ☐ - or + Rapid & PCR: ☐ - or + PCR Only: ☐

Have you experienced any of the following symptoms in the past 48 hours?

Symptoms	Yes	No
Fever or chills	☐	☐
Cough	☐	☐
Shortness of breath or difficulty in breathing	☐	☐
Fatigue	☐	☐
Sore throat	☐	☐
Congestion or Runny nose	☐	☐
Nausea or vomiting	☐	☐
Diarrhea	☐	☐

- **Please complete the form and bring to your appointment.**
- **Bring a paper copy of your current medication dosage and insurance card**

Patient Details:

First Name _____ Last Name _____

Street address _____

City _____ State_____Zip_____

SSN _____ Gender ○ Male ○ Female

Marital status ○ Single ○ Married ○ Divorced ○ Widow

Date of Birth _____ Phone No. _____

Email address _____

Insurance and billing details:

Primary INS _____ ID _____ Group _____

Subscriber name (if other than patient)

Subscriber DOB_____ Subscriber SSN _____

Secondary INS _____ ID _____ Group _____

Payment Mode:

Bill Insurance ☐ **No Insurance, Bill Uninsured Fund** ☐

Payments requested at the time of service unless prior arrangements have been made.
I hereby authorize direct payment of medical benefits of Huntington Hospitalist Group, Inc. to services rendered by them in person or under their supervision.
I understand that I am financially responsible for any balances not covered by my insurance.
I hereby authorize Huntington Hospitalist Group Inc to release any medical and accidental information that may be necessary for either medical care or in processing application for financial benefits.

Date **Patient Signature**

_____ _____