Drive-Thru Only
No-Cost COVID-19 Testing

Get tested for COVID-19

Every 1st & 3rd Wednesday
March-April
1:30pm - 5pm

Sierramont Middle School
3155 Kimlee Dr,
San Jose, CA 95132

- You MUST WEAR A MASK
- Appointment preferred, but not needed
- Staff will assist with translation and Medi-Cal enrollment at no cost
- Drive-thru only!

Call 408.755.3904 to register

For more information: bach.health | 408.755.3904 | Follow BACH on

Drive-Thru Solamente
Pruebas covid-19 sin costo

Hágase la prueba del COVID-19

Cada primer y tercer miércoles
marzo-abril
1:30pm - 5pm

Sierramont Middle School
3155 Kimlee Dr,
San Jose, CA 95132

DEBE DE USAR UNA MASCARILLA
Citas preferidas, pero no necesarias
Los empleados le ayudará con la traducción y inscripción de Medi-Cal, sin costo
El examen es solo en carro

Llame al 408.755.3904 pare regirstrarse

免費車內新冠肺炎測試

BAY AREA COMMUNITY HEALTH

請接受新冠測試

每月第一個和第三個 周三
三月-四月
下午1點半到五點

Sierramont Middle School
3155 Kimlee Dr,
San Jose, CA 95132

您必須戴上口罩
可以選擇預約
提供免費翻譯和申請白卡服務
免下車 服務

現在就打電話注冊408.755.3904

Chỉ Ngồi Trong Xe
Kiểm tra covid-19 miễn phí

BAY AREA COMMUNITY HEALTH

Trường học sẽ mở cửa lại, hãy thử nghiệm covid 19

Tháng 3 và Tháng 4
Thứ 4 vào tuần 1 và tuần 3 trong tháng

Sierramont Middle School
3155 Kimlee Dr,
San Jose, CA 95132

BẠN PHẢI ĐEO MẶT NẠ.
Nên gọi để lấy hẹn nhưng bạn không cần phải hẹn
Nhân viên sẽ hỗ trợ bạn thông dịch và ghi danh miễn phí để xét nghiệm

Gọi 408-755-3904 để lấy hẹn.

BAY AREA COMMUNITY HEALTH – Patient Registration

Revised 1/2021

Patient Name: _____
Last First Middle

Address: _____
Street Apt. # City ZipCode

Phone #: (_____)_____ (_____)_____ (_____)_____
Home Work Cellular

Date of Birth: _____ Sex at birth: ☐ Male ☐ Female
Month / Day / Year

Please indicate if it is OK for us to leave a confidential voice mail that may include test results, prescription information, or any other medical information pertaining to your health. This will reduce the need for your to return our call if you do not have any additional questions. This should be a phone number where **only you, or anyone that you are comfortable** with hearing your medical information.

Phone Number that is OK to leave message on (_____)_____ ☐ YES you may leave a message with health information
☐ Do not leave message with health information

How may we contact you? Please select all that apply: ☐ Mail ☐ Text ☐ Phone

Register for Patient Portal to get your result faster (HEALOW): ☐ Email: _____

Ethnicity: ☐ Non-Latino/Hispanic ☐ Latino/Hispanic	**Race:** ☐ White ☐ African American / Black ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander
Primary Insurance Information:	**Do you have Health Insurance?** ☐ Yes ☐ No If no, you will automatically be enrolled in a **COVID-19 Uninsured Program** by the *Health Resources & Services Administration* (HRSA) for your No-Cost Covid-19 Test/Vaccination. If yes, please provide your Health Insurance Information: ☐ Medi-Cal/Medicare ☐ Kaiser ☐ Valley Health Plan (VHP) ☐ Other _____ ☐ Anthem ☐ Anthem Bluecross / Blueshield ☐ Aetna ☐ Cigna Group Number: _____ ID Number: _____ Who is your current Primary Care Provider (your personal doctor): _____
In Case of Emergency Friend or Relative to Contact: _____ _____ (_____)_____ Name Relationship Telephone #	

Do you have any of the following Symptoms in the past two weeks?

Fever (Over 100.4):	☐ Yes	☐ No	Headaches:	☐ Yes	☐ No
Chills:	☐ Yes	☐ No	New loss of taste or smell:	☐ Yes	☐ No
Cough:	☐ Yes	☐ No	Sore throat:	☐ Yes	☐ No
Shortness of Breath:	☐ Yes	☐ No	Congestion or runny nose:	☐ Yes	☐ No
Difficulty Breathing:	☐ Yes	☐ No	Nausea:	☐ Yes	☐ No
Fatigue:	☐ Yes	☐ No	Diarrhea:	☐ Yes	☐ No
Muscle or Body Aches:	☐ Yes	☐ No	Generally Feeling unwell:	☐ Yes	☐ No
Have you been exposed to COVID-19: ☐ Yes ☐ No			Have you traveled in the past two weeks? ☐ Yes ☐ No		

How did you hear about us?

☐ Call Center ☐ Santa Clara County ☐ TV Station ☐ Temple
☐ Flyers ☐ Web Base ☐ Words of Mouth
☐ Our Patient ☐ On-site Poster ☐ BACH's Social Media

NEXT PAGE

CONSENT FOR TREATMENT

By signing below, I the undersigned patient (or authorized representative, or parent/guardian), consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and it's healthcare providers.

Patient Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

Bay Area Community Health (BACH) Notice of Privacy Practices gives information about how BACH may use and release protected health information (PHI) about you.
I understand that:

- I have the right to receive a copy of BACH's Notice of Privacy Practices
- I may request a copy at any time
- BACH's Notice of Privacy Practices may be revised

By signing below, I acknowledge the above and that I have received a copy of BACH's Notice of Privacy Practices.

Responsible Party: _____ **Date:** _____

Authorization to Release Medical Information

You are authorizing the disclosure of your personal information, which may include health information, to persons or organizations outside of Bay Area Community Health (BACH). Your privacy is protected by the state and federal privacy laws. As such, we need your explicit permission to make the requested disclosure.

Please complete each section of this form.

I, _____ understand that information disclosed to any of the person(s) listed below is no longer protected by federal or state law and may be subject to disclosure by the named person(s) listed below. I understand I have the right to revoke this authorization at any time in writing.

Check all that apply: (Print only)
☐ **Spouse / Partner:** _____
☐ **Children: 1)** _____
2) _____
3) _____
☐ **Other**:

I give permission for my medical provider to release the following to the person(s) listed above:
☐ **Share test results**
☐ **Share my medical condition**
☐ **Discuss or send message about appointments**

Patient Signature: _____ **Date:** _____