City of Chicopee – COVID-19 Testing Site
Intake Form

PLEASE PRINT CLEARLY

PATIENT LAST NAME _____

PATIENT FIRST NAME _____

DATE OF BIRTH (MM/DD/YYYY) _____

GENDER (Check One)

☐ MALE ☐ FEMALE ☐ UNKNOWN ☐ OTHER

EMAIL _____

ADDRESS _____

ADDRESS 2 _____

ZIP _____ CITY _____STATE _____

HOME PHONE ( ) _____ • MOBILE PHONE ( ) _____

RACE (Check One)

☐ AFRO-AMERICAN ☐ ASIAN ☐ OTHER

☐ NATIVE AMERICAN ☐ WHITE

☐ NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER

ETHNICITY GROUP (Check One)

☐ Yes HISPANIC

☐ Not HISPANIC or LATINO

MUNICIPAL EMPLOYEES ONLY:

Department _____ (Ex. Police, Fire, DPW, etc.)