# FLORIDA HEALTH
## IN MIAMI-DADE COUNTY

## DEMOGRAPHIC FORM

**SELECT THE CLINIC THAT YOU MADE THE APPOINTMENT AT. PRINT ONE FORM PER CLIENT AND BRING IT ON YOUR APPOINTMENT DAY.**

**Arrival Time** | **Appt. time** | **Walk-in Number** | **New Client Y-N** | **STATE IMM ID #**

**Last Name:** Apellido: Siyati:

**First Name:** Primer Nombre: Non:

**Middle Name:** Segundo Nombre: Lot Non:

**Sex: Male or Female** Sexo: Masculino o Femenino Sèks: Gason oswa Fi — M ☐ F ☐

**Race: Black/ White/Other** Raza: Negro/ Blanco/Otro Ras: Nwa / Blan / Lòt — B Negro Nwa ☐ W Blanco Blan ☐ Other: otro: lòt: ☐

Did the client have Varicella / Chickenpox? If so, what age
Al cliente le dio Varicella / "La China"? Si es asi, a que edad
Eske kiliyan an te gen Saranpyon / Varcella? Si Wi a ki laj
Yes ☐ No ☐ _____

**Date of birth:** Fecha de nacimiento: Dat li fèt — MM ____ DD ____ YY ____

**Home Address:** Direccion de su casa: Adrès Kay ou:

**Apartment Number:** Numero de apartamento: Nimewo Apatman:

**City:** Ciudad: Vil:

**State:** Estado: Eta

**Zip Code:** Codigo postal: Kòd Postal:

**Telephone:** Telefono: Nimewo telefòn: ( ) - -

**Country of birth:** Pais de nacimiento: Peyi nesans:

**Language:** Idioma: Lang:

**Email Address:** Correo electrónico: Imèl Adrès: @

**Does the client have any allergies? If so, specify:**
El cliente tiene algún tipo de alergia? Si es así, especifique:
Kliyan an gen alèji? Si se konsa, endike:

**What is the client's current insurance status:** ¿Cuál es el estado actual del seguro de el cliente tcheke youn nan kesyon yo asirans

**Private Insurance** Seguros Privado Asirans Prive ☐ | **Medicaid** ☐ | **No insurance** No Seguro Pa gen asirans ☐

**Name of Person filling out form:** Nombre de la Persona llenado el formulario Non Moun Ki Ranpli fòm nan: _____ DD/MM/YYYY

**What is your relationship with the client:** Cual es su relacion con el cliente: Ki relasyon w ak kliyan an:

**Mother:** Madre: Manman: ☐ | **Father:** Padre: Papa: ☐ | **Guardian:** Guardian: Gadyen: ☐ | **Myself:** **Yo mismo: tèt mwen** ☐

## VACCINES REQUESTED / VACUNAS SOLICITADAS / REQUESTED VAKSEN

HepA ☐ HepB ☐ | Hep **A/B** ☐ | HIB ☐ HPV ☐ IPV ☐ | Influenza ☐ | * Japanese Encephalitis ☐ | MMR ☐
Menactra ☐ | PCV 13 ☐ | PPSV 23 ☐ | * Rabies ☐ | Tdap ☐ Td ☐ * Typhoid ☐ | VZV ☐ | * Yellow Fever ☐

*** ONLY AVAILABLE IN OUR TRAVEL CLINIC AT HEALTH DISTRICT CENTER MIAMI**

# FOR OFFICE USE ONLY

**NO PPD** Needed ☐ | PPD on site ☐ | Referred for Physcal/PPD ☐ | Time client returned to clinic _____ | **DOH 680** Form ☐ | **DOH 681** Form ☐

**Registration Counter Time** | **Clerk's Start time** | **Clerk's End time** | **Initials**

**MEDICAID#** | **MEDICAID END DATE:**

# INITIATION OF SERVICES

**PART I** **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: ✔ _____
(If a Minor, Child's Name)

Name of Agency: FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE COUNTY

Agency Address: SELECT THE APPROPRIATED AGENCY ADDRESS.

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical visits including obtaining medical history, assessment, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

**PART II** **DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my health information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

**PART III** **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my health information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

**PART IV** **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above-named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

**PART V** **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

**PART VI** **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ _____ _____

Client/Representative Signature | Self or Representative's Relationship to Client | Date MM/DD/YYYY

_____ _____

Witness (optional) | Date MM/DD/YYYY

**DATE THE FORM WITH THE APPOINTMENT DATE.**

**PART VII** **WITHDRAWAL OF CONSENT**

I, _____ WITHDRAW THIS CONSENT, effective _____

Client/Representative Signature | Date

_____ _____

Witness (optional) | Date

Client Name: _____

ID#: _____

Original to file; Copy to client

DOB: _____
MM/DD/YYYY

DH 3204-SSG-09-2019