FLORIDA HEALTH IN MIAMI-DADE COUNTY

DEMOGRAPHIC FORM

SELECT THE CLINIC

HMS LABEL

Adult & Travel Forms

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 ☐ MM/DD/YYYY

Date of birth: Fecha de nacimiento: Dat li fèt — MM/DD/YYY

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: 0123456789

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:

TO BE COMPLETED IF CLIENT IS UNDER 18 YEARS OF AGE OR A DEPENDANT.

Mothers Name and Date of Birth: Nombre de Madre y fecha de nacimiento: Non Manman y Dat li fèt: MM/DD/YYYY

Fathers Name and Date of Birth: Nombre de Padre y fecha de nacimiento: Non Papa e Dat li fèt: MM/DD/YYYY

Guardian name: Nombre de Guardian: Gadyen lègal Non: MM/DD/YYYY

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

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 ☐ | Add recommended vaccines ☐

VACCINES REQUESTED / VACUNAS SOLICITADAS / REQUESTED VAKSEN

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

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

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

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 CLINIC

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 office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue the 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 medical 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 medical 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 MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

✔ _____ ✔ _____ ✔ ✔ _____
(Adult Client or Guardian's) Signature | Self or Representative's Relationship to Client | Date MM/DD/YYYY

_____ _____
Witness (optional) | Date

PART VI WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____
Client/Representative Signature | Date

_____ _____
Witness (optional) | Date

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

ID#: _____

DH 3204, 11/08 | Original to file Copy to client | DOB: ✔ _____
MM/DD/YYYY