



FLORIDA HEALTH  
IN MIAMI-DADE COUNTY

HMS LABEL

DEMOGRAPHIC FORM

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 [M] [ ] [F] [ ] Sexo: Masculino o Femenino Sèks: Gason oswa Fi 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 [ ] Home Address: [ ] Direccion de su casa: [ ] Adrès Kay ou: [ ] Apartment Number: [ ] Numero de apartamento: [ ] City: [ ] Ciudad: [ ] State: [ ] Estado: [ ] Telephone: [ ] Telefono: [ ] Zip Code: [ ] Código postal: [ ] Country of birth: [ ] Pais de nacimiento: [ ] Email Address: [ ] Correo electrónico: [ ] Does the client have any allergies? If so, specify: [ ] El cliente tiene algún tipo de alergia? Si es así, especifique: [ ]

TO BE COMPLETED IF CLIENT IS UNDER 18 YEARS OF AGE Mothers Name and Date of Birth: [ ] Fathers Name and Date of Birth: [ ] Guardian name: [ ] Name of Person filling out form: [ ] What is your relationship with the client: [ ] Mother: [ ] Father: [ ] Guardian: [ ] Myself: [ ]

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 [ ] MMR [ ] Menactra [ ] Menomune [ ] PCV 13 [ ] PPSV 23 [ ] \* Rabies [ ] Tdap [ ] Td [ ] Typhoid [ ] VZV [ ] \* Yellow Fever [ ] Zoster [ ] \* ONLY AVAILABLE IN OUR TRAVEL CLINIC AT HEALTH DISTRICT CENTER MIAMI

Registration Counter Time [ ] Clerk's Start time [ ] Clerk End time [ ] Initials [ ]



# INITIATION OF SERVICES

**PART I CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: \_\_\_\_\_

Name of Agency: \_\_\_\_\_

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 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**

\_\_\_\_\_  
Client/Representative Signature

\_\_\_\_\_  
Self or Representative's Relationship to Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness (optional)

\_\_\_\_\_  
Date

**PART VI WITHDRAWAL OF CONSENT**

I, \_\_\_\_\_ WITHDRAW THIS CONSENT, effective \_\_\_\_\_  
Client/Representative Signature Date

\_\_\_\_\_  
Witness (optional)

\_\_\_\_\_  
Date

Client Name: \_\_\_\_\_

ID#: \_\_\_\_\_

DOB: \_\_\_\_\_