

FLORIDA HEALTH IN MIAMI-DADE COUNTY

HMS LABEL

DEMOGRAPHIC FORM

	Appt. time	Walk-in Number	New client Y						
						STA	TE IMM ID #		
Last Name:									
Apellido:									
Siyati:									
First Name:									
Primer Nombre: Non:									
Middle Name:					Sex: Male or Fe	mala			
Segundo Nombre:					Sexo: Masculino		M] F []	
Lot Non:					Sèks: Gason osw	va Fi			
Race: Black/ White/O	. D -	W	Other:				•	If so, what age	
Raza: Negro/ Blanco	, Negro -	Blanco	otro:					s asi, a que edad	
Ras: Nwa / Blan / Lò Date of birth:	t Nwa	Blan	lòt:		Eske kiliyan an	te gen Saranpy	on / varcella	? Si Wi a ki laj	
Fecha de nacimiento:					Yes	□ No			
Dat li fèt					103	140			
Home Address:									
Direccion de su casa	i.								
Adrès Kay ou:			011	-				Otat :	
Apartment Number Numero de apartame			City: Ciudad					State: Estado:	
Nimewo Apatman:	ano.		Vil					Estado: Eta:	
Zip Code:			Telephone						
Codigo postal:			Telefono		_		-		
Kòd Postal:			Nimewo telefòn	:					
Country of birth:				L	anguage:				
Pais de nacimiento:					Idioma:				
Peyi nesans:					Lang:				
Email Address : Correo electrónico:									
Imèl Adrès:									
Does the client hav	e any allergies? I	f so, specify:							
El cliente tiene algún									
Kliyan an gen alèji?	3i se konsa, endike	e:							
Me	others Name an	nd Date of E	Birth:						
v No	ombre de Madre	y fecha de	nacimiento:						
L H H	on Manman y Da	at li fèt:							
AGE AGE	on Manman y Da on Manman y Da on Manne and		irth:						
CLIENT F AGE		d Date of B							
IF CLIENT (S OF AGE	others Name and ombre de Padre on Papa e Dat li	d Date of B y fecha de r							
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INITIATION OF SERVICES

PART I CLIENT-PROVIDER RELATE Client Name:					
Name of Agency:					
Agency Address:					
I consent to entering into a client-provider relat I understand routine health care is confidential a administration of medication, laboratory tests an	ionship. I authorize Department of Health staff and voluntary and may involve medical office v	and their representative visits including obtaining	es to render routine health care g medical history, examination		
PART II DISCLOSURE OF INFORMA	TION CONSENT (treatment, payment or h	ealthcare operations pur	poses only)		
I consent to the use and disclosure of my medical					
psychiatric/psychological, and case managemen	-				
PART III MEDICARE PATIENT CERTIF Medicare Clients)	FICATION, AUTHORIZATION TO RELE	ASE, AND PAYMEN	Γ REQUEST (Only applies to		
As Client/Representative signed below, I certify	that the information given by me in applying f	For payment under Title	XVIII of the Social Security		
Act is correct. I authorize the above agency to a	release my medical information to the Social Se	ecurity Administration o	r its intermediaries/carriers for		
this or a related Medicare claim. I request that p	payment of authorized benefits be made on my	behalf. I assign the ben	efits payable for physician's		
services to the above named agency and authori	ze it to submit a claim to Medicare for paymen	t.			
policy. The amount of such benefits shall not exare to be made to above agency. I am personally PART V MY SIGNATURE BELOW VERIGHTS	y responsible for charges not covered by this ass	signment.			
Client/Representative Signature	Self or Representative's Relationsh	ip to Client	Date		
Witness (optional)	Date				
PART VI WITHDRAWAL OF CONSENT					
I, WITHDRAW THIS CONSENT, effective					
Client/Representative Signature		Date			
Witness (optional)	Date				
DH 3204, 11/08	Original to file Copy to client	DOB:			