Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD.
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE COUNTY - PATIENT DEMOGRAPHIC FORM

SERVICE SITE: _____

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____
(APELLIDO) (PRIMER NOMBRE)
(SIYATI) (NON-OU)

DATE OF BIRTH: _____ **RACE:** _____ **SEX:** ☐M or ☐F
(FECHA DE NACIMIENTO) (RAZA) (SEXO) H o M
(DAT OU FÈT) (RAS) (SEKS) M OSWA F

STREET ADDRESS: _____
(DIRECCIÓN)
(ADRÈS LAKAY-OU)

CITY: _____ **ZIP CODE:** _____ **TELEPHONE:** _____
(CIUDAD) (CÓDIGO POSTAL) (TELÉFONO)
(VIL) (ZIP KOD) (TELEFÒN)

COUNTRY OF BIRTH: _____ **LANGUAGE:** _____
(PAÍS DE NACIMIENTO) (IDIOMA)
(PEYI OU FÈT) (LANG)

Provider's Use Only

Date:				**Allergies:** ☐ NKA		
Contraindication:				**Contraindicación Date:**		
✓	Vaccine Type (VIS Date)	VIS	Lot Number	Lot Number	Site	Route
					LAT - LDT / RAT -RDT	IM / SC
					LAT - LDT / RAT -RDT	IM / SC
					LAT - LDT / RAT -RDT	IM / SC
					LAT - LDT / RAT -RDT	IM / SC
					LAT - LDT / RAT -RDT	IM / SC
					LAT - LDT / RAT -RDT	IM / SC
					LAT - LDT / RAT -RDT	IM / SC
					LAT - LDT / RAT -RDT	IM / SC
					LAT - LDT / RAT -RDT	IM / SC
					LAT - LDT / RAT -RDT	IM / SC
					LAT - LDT / RAT -RDT	IM / SC

Client Signature: _____ **Provider Signature:** _____
Name: _____

Notes:
_____
_____
_____
_____
_____

Updated: 10/04/2021

Florida Department of Health in Miami-Dade County
Epidemiology, Disease Control and Immunization Services
8175 N.W. 12th Street, Suite 314
Miami, Florida 33126
PHONE: 305/470-5660 • FAX: 786/845-0598
http://miamidade.floridahealth.gov/programs-and-services/clinical-and-nutrition-services/immunizations/index.html

PHAB Accredited Health Department
Public Health Accreditation Board

INITIATION OF SERVICES

PART I CLIENT-PROVIDER RELATIONSHIP CONSENT

Client Name: ✔ _____

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

Agency Address: 1350 NW 14TH STREET MIAMI, FL 33125 (ANNEX BUILDING EPI-IS)

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#: _____

DH 3204, 11/08 Original to file Copy to client DOB: ✔ _____