Florida Department of Health in Leon County
Client Registration Form

Date (Fecha) ___________ Arrival Time (Hora) __________
Appointment Time (Hora de la cita) ___________________

Last Name (Apellido) _________________________________
First Name (Nombre) _________________________________
Middle Initial (Inicial) _________________________________
Social Security (Seguro Social No.) _____________________
Date of Birth (fecha de Nacimiento) ___________________
Male _______ Female_______ Race___________________
(Masculino) (Femenina) (Raza)

Address (Direccion)____________________________________
Apartment Number (Numero de Apartmento)____________
City ________________ State________ Zip _______________
(Ciudad) (Estado) (Codigo Postal)

Phone (Telephono)____________________________________

Reason for visit (Razon por la visita) ____________________
When was your last visit?______________________________

Have you been seen at another Health Department?
(Concurrio a otro Departamento de Salud?) Yes(Si) ☐ No ☐

If Yes, what location? (En que localidad?)________________
Has your income changed? Yes(Si) ☐ No☐
(Ha cambiado sus ingresod?)

Do you have insurance? (Tiene seguro?) Yes(Si) ☐ No☐
Medicaid☐ Medicare☐ Other(Otro)☐ Private Pay (Privado) ☐

Have you had Medicaid that ended? Yes (Si) ☐ No☐
(Ha termindado su cobertura de Medicaid?)

If Yes, when? (En caso affirmative, Cauando?)_____________
Parent's Name(Nombre de los padres)___________________
****

[OFFICE USE ONLY]

MD ☐ ARNP ☐ STD/RN ☐ NURSE ☐

FLORIDA DEPARTMENT OF HEALTH IN LEON COUNTY

Please list yourself below, **and if you have a spouse or children in the household,** please list them below also.

Name	SSN	Relationship	Marital Status	Date of Birth	Age	Race	Sex
		self					

Mailing Address: ____
(Street or P.O. Box) City State/Zip
Home Phone: ___________________________ Work Phone: __________________________________

Emergency Notification ____
(Name) (Phone) (Relationship)

You may be charged a fee for our clinic services based upon your monthly income and family size. Please provide the following information to assist us in determining your fee. You may request a review of the fee charged, if you feel that the most recent weeks of income is not representative of your family's customary monthly income. You have the right to refuse to give financial information, thereby accepting a fee equal to full charge for the service.

Are you covered by insurance? ______ If yes, please list below.

☐ Other/ Company Name ____________________ Account Number ___________________________
☐ Medicaid Account Number ___________________________
☐ Medicare Account Number ___________________________

Do you pay for childcare? ______________ How much per month? $________________

Do you pay child support? ______________ How much per month? $________________

IF ANY ADULT LISTED ABOVE IS EMPLOYED, PLEASE COMPLETE THIS SECTION

Name of Person Employed: ___________________ Name of Person Employed: ___________________
Place of Employment: ________________________ Place of Employment: ________________________
Gross Income: $_____________wkly/biwkly/mthly Gross Income: $_____________wkly/biwkly/mthly

ARE YOU UNEMPLOYED? ______YES _____NO ARE YOU A STUDENT? ______YES _____NO

Do you receive income from any of the sources listed below? Please list the amount received and how often it is received.
(Example: weekly, bi-weekly, monthly, per semester or yearly, etc.)

TANF $_________
Worker's Comp. $_________
Parental Support $_________
Pensions/Annuities$_________
Other $_________

Unemployment Comp. $_______
Child Support Received $_________
Family Support $_________
Loans $________________
(per semester/yearly)

Veteran's Pensions $_______
Social Security $_________
Rental Income Received $_________
Grants $______________
(per semester/yearly)

Number of Adults (____) and children (_____) dependent on this income.

TOTAL MONTHLY INCOME BEFORE DEDUCTIONS: $__________________

I certify that the information I have provided on this form is true and correct to the best of my knowledge. I understand that I may be declared ineligible for services if I knowingly provide false or inaccurate information. I give consent to Leon County Health Department to make changes in GROSS income in excess of $50 per month and any changes in my number of dependents. I authorize release of any medical information necessary to process this claim. I authorize payment of medical benefits to Leon County Health Department.

Signature:____ Date:_____________________________

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 CERTIFCATION, 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: ________________________

DH3204, (Approved 11/08) ***Original to file, Copy to client***

ADULT SELF-HEALTH HISTORY

Please read the attached instruction sheet and complete the questions on this form. The information obtained on this form will remain confidential and will be a part of your medical record.

Your Name: ______________________ Today's Date: ____/____/____

I. PATIENT AND FAMILY HISTORY: DO YOU, YOUR PARENTS, BROTHER(S), SISTER(S), GRANDPARENTS, HAVE ANY OF THE FOLLOWING:

	Yes	No	PROVIDER COMMENTS
1. Stroke/High Blood Pressure	☐	☐	
2. Heart Disease/Rheumatic Fever	☐	☐	
3. Diabetes/Sugar	☐	☐	
4. Cancer	☐	☐	
5. Birth Defects	☐	☐	
6. Blood Problems/Sickle Cell Disease/Rh	☐	☐	
7. Tuberculosis/Asthma/Lung Disease	☐	☐	
8. Severe Headaches/Blurred Vision/Seizures	☐	☐	
9. Emotional Health Problems/Depression	☐	☐	
10. Breast Disease	☐	☐	
11. Gall Bladder/Liver Disease	☐	☐	
12. Stomach/Intestinal Problems/Nausea & Vomiting	☐	☐	
13. Kidney or Bladder Problems	☐	☐	

II. PATIENT HISTORY: DO **YOU** HAVE ANY OF THE FOLLOWING:

	Yes	No	
1. Thyroid/Endocrine Disorder	☐	☐	
2. Blood Clots in Leg or Lungs/Varicose Veins	☐	☐	
3. Skin/Bone Problems	☐	☐	
4. Pelvic Infections/Disorders	☐	☐	
5. Did your mother have miscarriages/DES	☐	☐	
6. Serious Injuries/Hospitalization/Surgery	☐	☐	
7. Blood Transfusions	☐	☐	
8. Do you have any allergies? Drugs ______ Food/Other ______	☐	☐	
9. Are you taking any medications? Prescription ______ Over–the-counter ______ Herbal ______	☐	☐	
10. Do you have any other medical conditions?	☐	☐	

FOR OFFICE USE ONLY

NAME
DOB
ID NUMBER

Reviewed By: (Name and Title) ______________________

Date: ______________________

ADULT SELF-HEALTH HISTORY

III. OBSTETRICAL HISTORY: (Female Clients)			PROVIDER COMMENTS
1. How many times have you been pregnant? ______________			
2. How many living children do you have? ______________			
3. How many miscarriages/abortions have you had? ______________			
4. How many tubal pregnancies have you had? ______________			
5. Did you ever have problems getting pregnant?	Yes ☐	No ☐	
6. Any of your babies birth weight less than 5 lbs.?	Yes ☐	No ☐	
IV. BIRTH CONTROL METHOD HISTORY:			
1. What are you using to prevent pregnancies? ______________			
2. When did you last have **unprotected** sex? ______________			
3. Have you ever used a method of birth control? Method Date	Yes ☐	No ☐	
4. Did you have any problems with any method?	Yes ☐	No ☐	
V. SEXUAL HISTORY:			
1. How old were you when you first had sex? Age: ________			
2. How many sex partners have you had in the past year? ________			
VI. HEALTH PROMOTION:			
1. Have you ever smoked?	Yes ☐	No ☐	
2. Do you drink alcohol? If yes, Type ________ Amount ________	Yes ☐	No ☐	
3. Have you ever used street drugs?	Yes ☐	No ☐	
4. Are your immunization shots up to date?	Yes ☐	No ☐	
5. Do you eat 5 or more servings of fruits and/or vegetables daily?	Yes ☐	No ☐	
6. Have you had any change in your weight in the last 6 months?	Yes ☐	No ☐	
7. Do you exercise most days of the week for 30 minutes or more?	Yes ☐	No ☐	
8. Have you ever had a STD or HIV infection?	Yes ☐	No ☐	

(Syphilis, Gonorrhea, Chlamydia, or Herpes)

9. Do you wear your seat belt? Yes ☐ No ☐

Frequency ____________

10. What type of work do you do? ____________________

11. Do you go to school? Yes ☐ No ☐

12. Is there abuse or violence in your family? Yes ☐ No ☐

VII. HIV RISK ASSESSMENT (*For Office Use Only*)

Risk exposure from 1978. Sexual Relations with:

Male	Yes ☐	No ☐		
Female	Yes ☐	No ☐		
While injecting non-prescription drugs	Yes ☐	No ☐		
For drugs or money	Yes ☐	No ☐		

Victim of sexual assault	Yes ☐	No ☐
Injecting drug user	Yes ☐	No ☐
Bisexual Male	Yes ☐	No ☐
Person with HIV/AIDS	Yes ☐	No ☐
Person w/other HIV/AIDS risks	Yes ☐	No ☐

NAME
DOB
ID NUMBER

Reviewed by: (Name and Title)

____

Date ____________________