

PATIENT INFORMATION FORM

Date of Visit _____ Date of Birth _____ Sex at Birth - Male ☐ Female ☐
Social Security Number (optional) _____ Hispanic - Yes ☐ No ☐
Legal Last Name _____ Legal First Name _____ MI _____
Preferred Name _____ Race (e.g., Asian/ Black/ White) _____
Home _____ Cell _____ Email Address _____
Emergency Contact Name _____ Relationship _____
Phone Number _____

ONLY TO BE COMPLETED IF THE PATIENT IS 17 OR UNDER AND RECEIVING PEDIATRIC OR IMMUNIZATION SERVICES

Mother First and Last Legal Name _____ Date of Birth _____
Father First and Last Legal Name _____ Date of Birth _____
Your Name _____ Relationship to child _____
Legal Guardian - Yes ☐ No ☐
Emergency Contact Name _____ Relationship _____ Phone Number _____

May we contact you via email? Yes ☐ No ☐ Would you like a text message for appointment reminders? Yes ☐ No ☐

Electronic communication, which includes text messaging and email, may not be a safe and secure means of communication. Some of these communications from the Department of Health may contain confidential and protected health information. I understand and acknowledge that there are risks of communicating electronically, such as, but not limited to, lack of encryption, electronic interception by others, interception by persons with access to my devices, and inadvertent transmission to the wrong number or email address. Despite such risks, by answering "yes" to receiving electronic communications, I authorize the Department of Health to communicate by electronic means. I understand that I can revoke my consent at any time by signing an updated demographic form.

Would you like to complete an Advanced Directive today? Yes ☐ No ☐

An advanced directive (living will) allows someone to make medical decisions on your behalf if you are unable to.

Would you like to participate in the Health Information Exchange (HIE)? Yes ☐ No ☐

HIE allows your medical information to be available and viewed electronically by doctors and your medical team members. It is designed to provide quick access to medical records to make treatment more effective and efficient. Any authorized healthcare provider and their team who agrees to participate in HIE can electronically access and use your protected health information, if needed, to provide treatment to you.

Please list all family members living in your home and note monthly income if applicable

(Income includes all earnings from jobs, pensions, child support, social security, death benefit, alimony, unemployment/worker's compensation, veteran benefits, investments, trust funds, rental income, self-employment, Public Assistance, grants or any other income received.)

Name	Date of Birth	Social Security Number (optional)	Relationship	Monthly Income

I affirm the information I am providing is true and correct to the best of my knowledge. I understand if I provide false or inaccurate information services may be discontinued, and I may have to pay for all services received per the appropriate fee schedule. FAC Rule 64f-10.003(5).

Signature _____ Date _____

REVOCATION: I understand I have the right to revoke this authorization anytime. If I revoke this authorization, I understand I must do so in writing and I must present my revocation to the medical record department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company, Medicaid and Medicare.