17560 NW 27th Avenue, Suite 106
Miami Gardens, FL 33056
P: (305) 690-7851 F: (305) 390-3900

RECORDS RELEASE AUTHORIZATION

Patient Name: _____ D.O.B. _____
Print First/Last Name

SSN: _____ - _____ - _____ Phone: _____

Please check one of the following and include names, addresses and telephone numbers

_____ I hereby authorize that my medical records be released to Platinum Medical Centers, Inc.

_____ I hereby authorize Platinum Medical Centers to release my medical records to:

Provider / Facility Name: _____

Phone Number: _____ Fax: _____

I hereby authorize Platinum Medical Centers, Inc. to request/and or send my complete medical records as indicated above. I understand that these records are of a privileged and confidential status. I waive this status for the purpose contained within this authorization. I agree to hold harmless Platinum Medical Centers, Inc. from any responsibility including all costs, liability, damages of any nature, and attorney fees resulting directly or indirectly from Platinum Medical Centers, Inc. release of these records pursuant to this consent.

I acknowledge that I have read and understand this authorization and agree to the terms set forth above.

_____ _____ _____
Signature – (Patient/Parent/Legal Guardian) Relation Date

_____ _____
Printed Name Witness Signature

PATIENT INFORMATION SHEET

NAME:_____ DOB:_____ DATE:_____

ALLERGIES:_____

SOCIAL HISTORY:

Recreational Drug Use: Current / Past / Never

Smoking: Currently Past Never Packs/day:_____

Alcohol: Currently Past Never Drinks/day:_____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Medications	OTC and vitamins
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PERSONAL MEDICAL HISTORY: (Please circle/fill in all that apply)

ADHD	COPD	High Cholesterol	Peptic Ulcer
Alcoholism	Dementia	HIV	Psoriasis
Allergies, Seasonal	Depression	Hepatitis	Pulmonary Embolism (PE)
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Rheumatoid Arthritis
Anxiety	Diverticulitis	Kidney Stones	Sciatica
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Kidney Disease	Seizure Disorder
Arthritis	Eczema	Lupus	Sleep Apnea
Asthma	Emphysema	Liver Disease	Stroke
Bipolar	Gallstones	Macular Degeneration	Thyroid Disorder
Bladder problems/Incontinence	GERD (Acid Reflux)	Migraines	Ulcerative Colitis
Bleeding problems	Glaucoma	Nosebleeds	
Cancer:_____	Heart Disease	Neuropathy	
Carpal Tunnel	Heart Attack (MI)	Osteopenia/Osteoporosis	
Headaches	Hiatal Hernia	Parkinson's Disease	
Crohn's Disease	High Blood Pressure	Peripheral Vascular Disease	

Last Menstrual Period	Yes/No Date:____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dxa (Bone Density)	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

_____ _____

FAMILY HISTORY:

FATHER: Living: Age_____ Deceased: Age_____

Alcoholism	Blood Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Skin Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Lymph Cancer	Thyroid disorder	
Anemia	Asthma	Breast Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Prostate Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other:_____

MOTHER: Living: Age_____ Deceased: Age:_____

Alcoholism	Breast Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Blood Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Skin Cancer	Thyroid disorder	
Anemia	Asthma	Lymph Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Ovarian Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other:_____

Siblings:_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc.)

_____

_____

Patient signature:_____ Date:_____

Provider reviewed:_____ Date:_____

Patient Information Form

PLATINUM MEDICAL CENTERS, INC.

Thank you for choosing Platinum Medical Centers. Please completely fill out this form to ensure the fastest and best healthcare service. We may ask you to look over this information from time to time to make sure it stays up-to-date.

Patient name	Social Security Number
Date of Birth	Address
Home phone	Work phone
Mobile phone or pager	Email address
Employer	Occupation
Insurance company name and policy number/Primary (see your insurance card) _____ _____ Effective date_____	Insurance company name and policy number/Secondary (see your insurance card) _____ _____ Effective date_____
Primary care physician	
If you are covered under the policy of a spouse, partner, parent, or legal guardian, please tell us about them:	
Patient name	Social Security Number
Date of Birth	Address
Home phone	Work phone
Mobile phone or pager	Email address
Employer	Occupation