



17560 NW 27<sup>th</sup> 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: \_\_\_\_\_

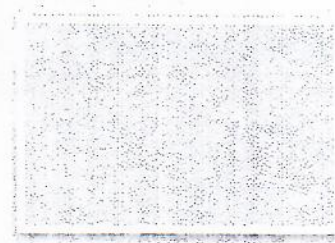
Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

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	Normal
	Date: _____	Abnormal
Colonoscopy	Yes/No	Normal
	Date: _____	Abnormal
Mammogram	Yes/No	Normal
	Date: _____	Abnormal
Dxa (Bone Density)	Yes/No	Normal
	Date: _____	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) _____ _____	Insurance company name and policy number/Secondary (see your insurance card) _____ _____
Effective date _____	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