Dr Candice Silverman Core Specialist Group – The Peak Program

Please circle the correct responses on this form

PERSONAL DETAILS

Title: *Mr/ Master /Mrs /Miss /Ms/ Dr/ Other*:_____ Today's Date: _____

Surname: _____ First & Middle Names: _____

Date of Birth: _____ Age: _____ Gender*: Male/ Female/ Non-Binary/ Transgender*

Are you of Aboriginal or Torres Strait Islander Origin: *Yes/ No* Mobile:_____

Address: _____ Suburb: _____

Post Code: _____ State: _____ Email: _____

Next of Kin:_____ Next of Kin's Mobile Number: _____

Relationship of Next of Kin: _____ Medicare Number: _____

Medicare Ref No: _____ Expiry Date: _____

Health Fund:_____ Health Fund Number: _____

Dept of Veteran Affairs: _____ White/ Gold: _____

Name of GP: _____ Name of Referrer: _____

MEDICAL HISTORY and HEALTH DETAILS

*Do you smoke: *Yes / No* * Do you drink alcohol: *Yes/ No*. *What is your current weight: _____kgs

*What has been your highest weight _____kgs and lowest weight _____kgs as an adult?

* What is your height: _____ Allergies: _____

*Please list any significant surgeries: _____

_____

*Have you been diagnosed with any significant medical conditions: _____

*Are you on any regular medications? Yes/No. Please list _____

PSYCHOLOGICAL HISTORY

(1) Do you suffer from anxiety: *Yes/ No* (2) Do you suffer from a lowered mood/depression: *Yes/ No*

(3) Have you been diagnosed with a mental health condition: *Yes/ No*

If yes what diagnosis was given and when: _____

(4) Have you ever been diagnosed with an Eating Disorder: *Yes/ No*

If yes, what eating disorder were you diagnosed with and when? _____

(5) In the last 3 months, have you had any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar time period? *Yes/ No*

(6) If Yes, did you feel distressed about your episode of excessive eating? *Yes/ No*

(7) Do you see a psychologist or psychiatrist? Yes/ No If yes what is their name: _____

ADDITIONAL INFORMATION

How did you hear of Dr Silverman: Internet/ Google Search/ Friend/ GP/ Other: _____

Specialist Group – Consent to Collect Patient Information- Privacy Act 2002

We require your consent to collect personal information about you. Please read this information carefully, and sign where indicated below. This medical practice collects information about you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

1. **Administrative purposes** in running our medical practice.
2. **Billing purposes**, including compliance with Medicare and Health Insurance Commission requirements.
3. **Disclosure to others involved in your health care**, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, discussing a treatment plan at a multi-disciplinary meeting with other Surgeons, Radiologists, Psychologists, Psychiatrist, Dieticians, Pathologists and Oncologists or requesting medical tests, reports or results provided to us following the referrals.
4. **My Health Record** – I give permission for Dr to access My Health Record if required.
5. **Multidisciplinary Meetings**-If your case is discussed at a multi-disciplinary meeting, all attending Specialists are able to bill Medicare direct for their time. There will be no out of pocket expense for you.

- I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.
- I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.
- I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.
- I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.
- I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of, as written below.

Full Name ……. Date……..…..

Signature: ……

Core Specialist Group Financial Policy

- It is our policy for all fees to be paid on the day of consultation, which you will have been made aware of either at the time of booking or on confirming your appointment. Payment by Eftpos, cash or credit card will be accepted; however, we do not accept personal cheques.

  By signing this form you have read and understood the terms of Core Specialist Group Financial Policy.

Signature: …… Date……..…..