ADVANCED INTEGRATIVE MEDICINE

**Terese A. Taylor, M.D.**

*Family Medicine and Medical Aesthetics*

**Date:** _____

**Patient Name:** _____
**Last** **First** **M.I.**

**Date of Birth:** _____/_____/_____

**Home Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Home Phone:** _____ **Cell Phone:** _____

**Marital Status:** _____ **Email:** _____

**Occupation:** _____

**Employer Phone:** _____

**Pharmacy & Phone #:** _____

**Spouse or Significant Other:**

**Name:** _____ **Home Phone:** _____

**Address :**_____ **City:**_____ **State:**_____ **Zip:** _____

**Employer:** _____ **Work Phone:** _____

**In Case of Emergency Please Notify :** _____

**Relationship:** _____ **Phone:** _____

**Referred to our office by:** _____

## AGREEMENT FOR PAYMENT OF SERVICES:

We believe that prompt payment for services is part of the contract that exists between doctor and patient. I understand that I am responsible for all charges incurred by me and I understand that I am required to pay them at the time services are rendered.

**No Show Policy:** The 1st will be charged a $75.00 fee, the 2nd will be $100.00 and the 3rd will be assessed a $150.00 fee and not rescheduled.

**Our return check charge is $25.00 for insufficient checks.**

Signature: _____Date: _____

Signature of Parent if Minor :_____ Date: _____

**Phone:** 239.540.9918 | **Fax:** 239-540-9921 | **Address:** 4202 Del Prado Blvd. S., Cape Coral FL, 33904

www.DrTereseTaylor.com

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# Patient Medical History

**Please fill this form out completely and bring it with you to your first appointment.**

**Name:** _____ **Date of Birth:** _____

**Allergies:** _____

**My allergic reaction was:** _____

**Do you take medication (circle one)? YES / NO**

**Medications (including supplements, herbs, aspirin, etc.):** _____

## Past Medical History:

*(Mark any of the following you have been diagnosed with or treated for)*

| | | | |
|---|---|---|---|
| ☐ Acne | ☐ Bleeding Disorders | ☐ Asthma | ☐ Heart Disease |
| ☐ High Blood Pressure | ☐ Anxiety | ☐ CVA/Stroke | ☐ Myasthenia Gravis |
| ☐ Migraines | ☐ Hepatitis | ☐ Lupus | ☐ Alcohol / Drug Addiction |
| ☐ Kidney Disease | ☐ Herpes / Cold Sores | ☐ Seizures | ☐ Liver Disease |
| ☐ Depression | ☐ Mitral Valve Prolapse | ☐ Keloids | ☐ Thyroid Disease |
| ☐ HIV | ☐ Diabetes | | |

☐ Cancer: _____

☐ Other (please specify): _____

Have you ever filed a lawsuit or complaint with a state-regulating agency against a physician? (circle one): **YES / NO**

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## Past Cosmetic Procedure History:

*(Mark any of the following that apply)*

☐ **Peels:** ☐ **TCA** ☐ **OBAGI** ☐ **PCA Skin**

☐ **Skin care:** ☐ **OBAGI** ☐ **PCA Skin** ☐ **Skin Medica** ☐ **Neo Cutis**

☐ **Botox, Dysport, Xeomin**

☐ **Restylane**

☐ **Juvederm**

☐ **Belotero**

☐ **Versa**

☐ **Radiesse**

☐ **Sculptra**

☐ **Nova Threads**

☐ **Kybella**

☐ **Ultherapy Skin Tightening**

☐ **Latisse**

☐ **Laser, treatments received:** _____

☐ **Plastic surgery, areas treated:** _____

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**Social History**:

Do you smoke (circle one): **YES / NO**

## Cosmetic Interest Questionnaire

Would you be interested in any of the following? (Check all that apply)

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| | | | |
|---|---|---|---|
| ☐ **Chemical Peels** | ☐ **Skin Care Products** | ☐ **Juvederm** | ☐ **Retin-A** |
| ☐ **Botox, Dysport, Xeomin** | ☐ **Restylane** | ☐ **Sculptra** | ☐ **Belotero** |
| ☐ **Versa** | ☐ **Radiesse** | ☐ **Ultherapy Skin Tightening** | ☐ **Nova Threads** |
| ☐ **Kybella** | ☐ **Latisse** | | |

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**How did you hear about our practice?**

| | | | |
|---|---|---|---|
| ☐ **Physician** | ☐ **Friend / Family** | ☐ **Seminar** | ☐ **Insurance Co.** |
| ☐ **Internet** | ☐ **Email forwarded** | ☐ **Advertisement or Article** | |

**If you were referred by one of our patients, please share his/her name so that we can thank him / her.**

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What cosmetic procedures, if any, have you had in the past? _____

Were you pleased with the outcome? If not, why?_____

If our office held a seminar for patients to learn more about certain cosmetic procedures, would you attend?
**YES / NO**

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