ADVANCED INTEGRATIVE MEDICINE

TERESE TAYLOR M.D.

DrTereseTaylor.com

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: _____

ADVANCED INTEGRATIVE MEDICINE
TERESE TAYLOR M.D.
DrTereseTaylor.com

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

ADVANCED INTEGRATIVE MEDICINE
TERESE TAYLOR M.D.
DrTereseTaylor.com

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: _____

ADVANCED INTEGRATIVE MEDICINE
TERESE TAYLOR M.D.
DrTereseTaylor.com

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)

☐ Chemical Peels ☐ Skin Care Products ☐ Retin-A

☐ Botox, Dysport, Xeomin ☐ Restylane ☐ Belotero

☐ Versa ☐ Radiesse ☐ Nova Threads

☐ Kybella ☐ Latisse

☐ Juvederm

☐ Sculptra

☐ Ultherapy Skin Tightening

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.

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