



ADVANCED  
INTEGRATIVE  
MEDICINE

TERESE TAYLOR M.D.

[DrTereseTaylor.com](http://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 1<sup>st</sup> will be charged a \$75.00 fee, the 2<sup>nd</sup> will be \$100.00 and the 3<sup>rd</sup> 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: \_\_\_\_\_



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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)

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

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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?

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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