Name_____ **DOB**_____

Female

Estrogen Dominance/Progesterone Deficiency Questionnaire

This questionnaire lists symptoms and other factors most commonly found in women suffering from this condition. By answering this questionnaire, your scores will determine whether or not you might have estrogen dominance/ progesterone deficiency. If you answer yes to any of the questions listed, please **circle** the number to the right of the question and total your score separately at the bottom of each table.

Do you have premenstrual breast tenderness?	4
Do you have premenstrual mood swings?	4
Do you have premenstrual fluid retention and weight gain?	4
Do you have premenstrual headaches?	4
Do you have migraine headaches?	3
Do you have severe menstrual cramps?	4
Do you have heavy periods with clotting?	3
Do you have irregular menstrual cycles?	3
Do you have uterine fibroids?	3
Do you have fibrocystic breast disease?	3
Do you have endometriosis?	2
Have you had problems with infertility?	2
Have you had more than one miscarriage?	2
Do you have joint pain?	1
Do you have muscle pain?	1
Do you have decreased libido?	3
Do you have anxiety or panic attacks?	2

Total _____

If your total score is **less than 4 points**, it is not likely that you have estrogen dominance/ progesterone deficiency. Scoring **between 5-8 points** indicates estrogen dominance/progesterone deficiency. A score **between 9-20 points** indicates estrogen dominance/progesterone deficiency is likely. A score **above 20 points** would suggest that estrogen dominance/ progesterone deficiency is very likely.

Perimenopausal and Menopausal Symptoms of Low Estrogen Questionnaire

This questionnaire lists symptoms and other factors most commonly found in women who are either perimenopausal or menopausal, and suffering from low estrogen. By answering this questionnaire, your scores will determine whether or not you might have low estrogen.

Do you have hot flashes?	4
Do you have night sweats?	4
Do you have vaginal dryness?	3
Do you urinate frequently?	2
Are you depressed?	2
Do you have difficulty sleeping?	3
Have you lost interest in sex?	2
Have your periods ceased?	4

Total _____

If your total score is **less than 4 points**, it is not likely that you have low estrogen. Scoring **between 5-9 points** indicates low estrogen is likely. A score **above 9 points** would suggest that low estrogen is very likely.

Yeast Overgrowth Questionnaire

This yeast questionnaire lists symptoms and other factors most commonly found in people suffering from **yeast overgrowth**. By answering this questionnaire, your scores will determine whether or not you might have yeast overgrowth. If you answer yes to any of the questions listed, please **circle** the number to the right of the question and total your score separately at the bottom of each table.

Do you have fatigue?	3
Do you feel lethargic?	2
Have you taken antibiotics multiple times during your life?	3
Do you have abdominal bloating, cramping or gas?	3
Do you have indigestion or heartburn?	2
Do you have abnormal bodily reactions to wine, beer or alcoholic beverages (i.e. flushing, headaches, sinus congestion or itchy skin)?	2
Do you crave sugar or bread products?	2
Do you have difficulty concentrating?	1
Do you have depressed moods?	1
Do you develop skin rashes or hives?	2
Do you have athlete's foot?	4
Do you have jock itch?	4
Do you have rectal itching?	3
Do you have fungal infection under the toenails or fingernails?	3
Do you have allergy symptoms?	1
Do you have recurrent respiratory infections?	1
Do you have joint pain?	1
Do you have muscle pain?	1
Do you have recurrent vaginal yeast infections?	4

Total _____

If your score is **less than 9 points**, it is not likely that you have yeast overgrowth. Scoring **between 10-16 points** indicates yeast overgrowth is a possibility. A score **above 16 points** indicates that yeast overgrowth is very likely.

Adrenal Fatigue Questionnaire

This questionnaire lists symptoms and other factors most commonly found in people suffering from adrenal fatigue. By answering this questionnaire, your scores will determine whether or not you might have adrenal fatigue.

Do you have fatigue?	3
Do you have allergies?	3
Do you have asthma?	3
Do you have recurrent infections?	3
Are you under severe emotional stress?	3
Do you suffer from chronic pain or physical?	3
Do you have low blood pressure?	2
Do you have a low pulse rate (less than 70 bpm without exercise)?	2
When you rise quickly, do you feel as though you might pass out?	2
Do you have depressed moods?	2
Do you have joint pain?	2
Do you have muscle pain?	2
Do you have low libido?	2
Do you have hair loss?	2
Do you have anxiety attacks?	2

Total _____

If your total score is **less than 6 points**, it is not likely that you have adrenal fatigue. Scoring **between 7-12 points** indicates adrenal fatigue is a possibility. A score **above 12 points** would suggest that adrenal fatigue is very likely.

Low Thyroid Questionnaire

This questionnaire lists symptoms and other factors most commonly found in people suffering from low thyroid or hyperthyroidism. By answering this questionnaire, your scores will determine whether or not you might have low thyroid. If you answer yes to any of the questions listed, please **circle** the number to the right of the question and total your score separately at the bottom of each table.

Do you have fatigue?	4
Do you have elevated cholesterol?	4
Do you have difficulty losing weight?	2
Do you have cold hands and feet?	2
Are you sensitive to the cold?	2
Do you have difficulty thinking?	2
Do you find it hard to concentrate?	2
Do you experience brain fog?	2
Do you have poor short term memory?	2
Are your moods depressed?	2
Are you experiencing hair loss?	2
Do you have less than one bowel movement per day?	2
Do you have dry skin?	2
Does your skin itch in the winter?	1
Do you have fluid retention?	2
Do you have recurrent headaches?	1
Do you sleep restlessly?	1
Are you tired when you awaken?	2
Do you have afternoon fatigue?	2
Do you have experience tingling or numbness in your hand or feet?	2
Do you have decreased sweating?	2
Have you had problems with infertility or miscarriages?	2
Do you have recurrent infections?	2
Do your muscles ache?	2
Do you have joint pain?	2
Do you have thinning of your eyebrows or eyelashes?	2
Is your tongue enlarged with teeth indentations?	2
Is your skin pasty, puffy or pale?	2
Do you have decreased body hair?	2
Is your voice hoarse?	1
Do you have a slow pulse?	2
Do you have a low blood pressure?	2
Does your body temperature run below the normal 98.6?	4
Do you have sleep apnea?	2

Total _____

If your total score is **less than 10 points**, it is not likely that you have low thyroid. Scoring **between 11-30 points** indicates low thyroid as a possibility. A score **above 30 points** would suggest that low thyroid is very likely.

Jill A. Taylor, DO

Family Practice

History & Physical

Name _____ SS#_____ Date_____
Address _____ Occupation_____
Phone (Primary) _____ (Secondary) _____ Date of Birth _____Age _____
Chief complaint _____

Drug Allergies

_____
_____
_____
_____
_____

Current Meds

_____
_____
_____
_____
_____
_____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□
Stroke	□	□	□	□	□	□
Cancer	□	□	□	□	□	□
Glaucoma	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□
Epilepsy/Convulsions	□	□	□	□	□	□
Bleeding Disorder	□	□	□	□	□	□
Kidney Disease	□	□	□	□	□	□
Thyroid Disease	□	□	□	□	□	□
Mental Illness	□	□	□	□	□	□
Osteoporosis	□	□	□	□	□	□

Hospitalization or Surgery

Reason	Date	Reason	Date

Women only: Pregnant? Yes No Planning Pregnancy? Yes No

Medical History

□ Headache _____
□ Shortness of breath _____
□ Heart palpitations _____
□ Heart murmur _____
□ Chest pain _____
□ Dizziness/Fainting _____
□ Peripheral vascular disease _____
□ Allergies/Hay fever _____
□ Asthma _____
□ Bronchitis _____
□ Pneumonia _____
□ Ulcer _____
□ GI disorder_____

□ Lactose intolerance _____
□ Gallbladder disease _____
□ Prostate disease _____
□ Bowel irregularity _____
□ Incontinence _____
□ Sexual/menstrual dysfunction _____
□ Venereal disease _____
□ Frequent infections _____
□ Hepatitis _____
□ Anemia _____
□ Arthritis _____
□ Osteoporosis _____
□ Nervousness _____

□ Depression _____
□ Gout _____
□ Scarlet fever _____
□ Chronic rashes _____
□ Rheumatic fever _____
□ Mumps _____
□ Measles _____
□ Rubella _____
□ Polio _____
□ Diphtheria _____
□ Tetanus _____
□ Other _____
□ Other _____

Habits

□ Smoke: Packs daily _____
How long? _____
Interested in stopping? _____
□ Exercise routine: _____
_____
_____

□ Coffee: Cups daily _____
Other caffeine _____
□ Alcohol: Type _____
Amount _____
□ Diet: Salt intake _____
Fat intake _____

□ Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring _____
Early morning awakening _____
Daytime drowsiness _____
Other _____

Hepatitis C risk factor

□ Blood transfusion prior to 1992
□ IV drug use (1+ times)
□ Contact with blood/bodily fluid
□ Tattoos
□ Shared razor/toothbrush
□ Body piercing

Taylor Family Practice

1806 Humble Place Drive • Humble, TX 77338 • Ph: 281-359-4220 • Fax: 281-359-4208

Taylor Family Practice
Dr. Jill A. Taylor

Phone#: 281-359-4220
Fax#: 281-359-4208

Authorization for Release of Healthcare Information

Patient Name: _____ DOB: _____

I hereby authorize the transfer/receipts of the following healthcare information:

To: **Taylor Family Practice**
1806 Humble Place Drive
Humble, TX 77338

From previous Doctor:
_____
_____
_____

Phone#: _____
Fax#: _____

****MOST RECENT ONLY**** **___ Pap** **____ MAMMOGRAM** **____ LABS**

Purpose of Disclosure: _____ Continuing Patient Care **_____ Other**

I understand the specific information to be released may include, but is not limited to the history, diagnosis and/or treatment of drug or alcohol abuse, mental/psychiatric related illness or communicable disease, including human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand the consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The revocation must be in writing and delivered to Taylor Family Practice Medical Record Department. It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. Information used or disclosed pursuant to this to this authorization may be subject to re-disclosure by the recipient and is no longer protected. Taylor Family Practice, its employees and partners and providers are released from legal responsibility for the release of the above information to the extent indicated and authorized herein.

_____ _____ _____ _____
(Signature of Patient) (Date) (Signature of Patient's Representative) (Date)

Patient Registration

Date _____

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

Patient Information

Social Security # _____
First Name _____ Middle _____
Last Name _____
Sex _____ Date of Birth (MM/DD/YY) _____
Marital Status □ Married □ Single
□ Divorced □ Widowed
(Check one) □ Employed □ Retired □ Full Time Student
□ Other _____
Employer _____

Home Address _____
_____
City _____ State _____ ZIP _____
Email _____
Primary Phone (____) _____
Secondary Phone (____) _____
Referring Physician _____
How did you hear of us? _____

Your Pharmacy Information

Pharmacy's Phone Number: _____

Name of Pharmacy: _____
Zip Code: _____ Street/Address: _____

Insurance Information

****PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST****

Insurance Company _____
Insured/Card Holder's Name _____ Relationship _____
Policy # _____ Group # _____ Phone (___) _____

Emergency Contact

First Name _____ Middle _____
Last Name _____
Relationship _____

Sex _____
Primary Phone (____) _____
Secondary Phone (____) _____

Spouse/Guarantor/Responsible Party

First Name _____ Middle _____
Last Name _____
Address _____
City _____ State _____ ZIP _____

Sex _____ DOB (MM/DD/YY) _____
Primary Phone (____) _____
Employer _____
Relationship _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing that I am responsible to pay non-covered services.	_____ Signature (Patient or Parent if Minor) Date
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.	_____ Signature (Patient or Parent if Minor) Date
AUTHORIZATION OF ELECRONIC COMMUNICATION: I hereby authorize Taylor Family Practice to send and receive appointment reminders to me via electronic communication (i.e. Email, Text message, etc.).	_____ Signature (Patient or Parent if Minor) Date
AUTHORIZATION OF ELECRONIC COMMUNICATION: I hereby authorize Advantages Pharmacy to send and receive electronic communication (i.e. Email, Text message, etc.) regarding, but not limited to, filling, refilling and authorizations of prescriptions.	_____ Signature (Patient or Parent if Minor) Date

Taylor Family Practice

1806 Humble Place Dr. • Humble, TX 77338 • Ph: 281-359-4220 • Fax: 281-359-4208

Your Health Care is Always Our Priority at Our Practice

We would like to inform you of the guidelines set by your insurance carrier regarding appointments for certain kinds of visits as well as authorizations for testing and referrals to specialists and laboratory utilization of blood work.

Emergency Care:

Those medical situations which a participant reasonably believes his of her life, or the life of a dependent, is in danger, or that permanent disability might result if the condition is left untreated (i.e. severe trauma, severe bleeding, loss consciousness, seizures, chest pain, poisoning, etc.). Participants must dial 911 or go to the nearest hospital's emergency room.

Acute Care:

Non-urgent problems that do not substantially restrict normal activity but could develop if left untreated (i.e. sinus infection, cold, earaches, headaches, etc.) Acute care will be provided as soon as an appointment is available with any of the office's practitioners (usually within 3 business days).

Urgent Care:

Urgent medical problems are those which, though not life-threatening, could result in serious injury or disability unless medical attention is received (i.e. high fever, animal bites, vomiting, diarrhea, etc.) or substantially restrict a participant's activity (i.e. infectious illness, flu, respiratory ailments, etc.). Participants needing urgent care will be seen usually within 24 hours or the first available appointment.

Well Care:

Well care refers to care for those needs that do not restrict a participant's activity (i.e. complete physical, well child care, immunizations, pap and pelvic exams, etc.). Participants needing well care will be seen within 60 calendar days.

The following list will give you approximate times necessary to receive results of the completed services indicated below:

Mammogram Results:	20-40 business days
Blood work Results:	20-30 business days
X-Ray Results:	7-10 business days
Pap Results:	20-30 business days

****Abnormal Results: You will be called to make an appointment to return to office. ****

Non-Urgent Referrals:	7-10 business days (referral can be picked up or faxed to the doctor.)
Stat Referrals:	1-2 business days (your doctor determines urgency of referrals.)
	Forms needing to be filled out: An office visit is required to verify that correct information appears on the forms.
	Prescription Refills: 4 business days (refills need a recent office visit within 3 months. There will be no narcotic refills over the phone. One month advance for mail-in script or routine needs.)
Prior Authorizations	Prescription Prior Authorizations are done through Cover My Meds Portal. If required, there is a $25.00 **non-refundable** fee whether approved or denied and may take 7 business days to process.

****WE DO NOT RECEIVE REFILL REQUESTS VIA FAX FROM PHARMACY****

_____ _____

Patient Signature Date

Acknowledgement and Authority

I consent to treatment from either Dr. Jill A. Taylor or any of her associated practitioners, as necessary or desirable for the care of the patient named on the form. This including, but not restricting to any drugs, medications, lab tests or other studies which may be used by the physician of his/her qualified, designated associate practitioners practicing at her office.

I acknowledge full responsibility for payment of such services and agree to pay my bill in full at the time of service. I understand that insurance coverage is an arrangement between the insurance carrier and the patient. Taylor Family Practice, as a courtesy to me, will assist in billing my insurance company, but I am ultimately responsible for the payment should my insurance fail to pay within a reasonable period of time.

I authorize Dr. Jill A. Taylor, D.O. to release information as required to my insurance or third party payer (including my employer or worker compensation carrier) for the purpose of determining benefits. I understand that such records may include information regarding having HIV/AIDS testing, substance abuse and/or mental health issues. I also authorize Taylor Family Practice to bill my insurance or third party payer and receive payment directly from them for services rendered.

The authorization shall remain valid until I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

_____

Patient Name

_____ _____

Signature of Patient, Parent or Guardian Date

Revised 5/10/12

Health Insurance Portability and Accountability Act (HIPAA)
Privacy Compliance Patient Questionnaire

All patients have the right to have confidential care provided. All information, medical, or social (whether written, spoken, electronic or computer generated) is to be held in strict confidence. Please fill out this information in order for Taylor Family Practice to provide better service.

If anything is seriously abnormal, our office will notify you by telephone, letters are sent out regarding other tests. If you are not notified, please DO NOT assume everything is normal. Call our office if it has been over six weeks since your test and you are not notified.

1. Please list the family members or other persons, if any, whom we may inform about general medical condition and your diagnosis. Please list complete name and phone number:

   _____

   _____

2. Please list the family members or significant others (if any) whom we may inform about your medical condition ONLY IN EMERGENCY. Please list complete name and phone number

   _____

3. Please print the address of where you would like your billing statements and/or Correspondence from our office to be sent:

   _____

   _____

4. Please print the telephone number and Email address (if any) where you want to receive calls about your appointments, lab and x-ray results or other healthcare information:
   Phone Number: _____
   Email Address: _____
5. Can confidential messages (including appointment reminders) be left on your home answering machine or voicemail? Yes _____ No _____
6. If you DO NOT have voice mail, can a message asking you to call us about results or to confirm your appointment be left at your place of employment? Yes _____ No _____
7. Are you moving in 30 days, or changing home or work phone number? If so, please notify our office as soon as you have your new information in order for us to contact you with any test results or provide information below:
   New address and effective date:

   _____

   _____

   New phone number(s) and effective date: _____

_____ (Guardian if under 18 years old)
Patient Name (Printed)

_____ _____
Patient/Guardian Signature Date

Taylor Family Practice

Advance Patient Notice Form

Your physician may refer you to, or arranging for you to receive services from, a non-participating physician, provider or facility for certain healthcare services. You have the right to receive services at a participating facility or by a participating physician or provider in order to obtain full benefits under your health coverage. If you have questions or would like to locate an in-network physician, provider or facility to provide the service or procedure, please contact Customer Service at the telephone number listed on the back of your insurance identification card.

Patient Name:	
Phone:	**Member ID#:**

To be completed by the patient or patient's legal guardian:

By placing my signature on this waiver form below, I acknowledge the following:

1. I am aware that the non-participating facility/provider that **MAY** be involved in my care **MAY** not participate with my insurance.
2. I understand that I **MAY** be responsible for additional costs for all services provided by the non-participating facility/provider, as specified in my benefit contract.
3. I was given an opportunity to contact my insurance company before obtaining these services to confirm my benefits for these non-network services and to obtain names of participating facilities and/or participating providers that can provide the recommended service or procedure.
4. I understand that absent special circumstances (e.g., financial hardship), the non-participating facility/provider is **PROHIBITED** from waiving co-payments, deductibles, coinsurance or other member cost sharing amounts.
5. I **MAY** voluntarily choose on behalf of myself or my child/legal guardian to obtain the service or procedure from the non-participating facility and/or physician.

_____ _____ _____ _____

(Signature of Patient) (Date) (Signature of Patient's Representative) (Date)