

PATIENT INFORMATION AND MEDICAL HISTORY

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ E-mail Address _____

Date of Birth _____ Age _____ Sex _____

HISTORY

Please check if you have or have had –

Diabetes	_____	Irregular menses	_____
Hepatitis	_____	Heart problems	_____
Herpes	_____	Hysterectomy	_____
Menopause	_____	Hypertension	_____
Sensitive to anesthetic	_____	Photosensitive Disorder	_____
Lupus	_____	Autoimmune illness	_____

Are you under the care of a physician? _____

Current/Recent medications _____

			<u>IF YES, EXPLAIN</u>
Keloid scars	Yes	No	_____
Hives	Yes	No	_____
Skin Cancer	Yes	No	_____
Waxing	Yes	No	_____
Electrolysis	Yes	No	_____
Cold Sores	Yes	No	_____
Hypersensitivity to skin products	Yes	No	_____
Skin Infections	Yes	No	_____
Tanning within the last 6 wks	Yes	No	_____
Use of acne products/drugs	Yes	No	_____
Laser skin resurfacing	Yes	No	_____
Chemical Peels	Yes	No	_____
Photo sensitizing substances	Yes	No	_____
Laser work of any type	Yes	No	_____

Medical Illness _____

Are you pregnant? _____

Allergies of any kind including drugs _____

Areas of interest for aesthetic treatment _____

Type of treatment requested Botox/ Filler _____

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature _____ Date _____

INFORMED CONSENT FOR BOTULINUM TOXIN INJECTION (BOTULINUM TOXIN TYPE-A AS BOTOX FROM ALERGAN)

FOR THE TEMPORARY TREATMENT OF SUPERFICIAL FACIAL WRINKLES

Please initial after each statement and sign at the bottom.

Botox is the botulinum toxin and works by paralyzing nerves and muscles.

1. I, _____, consent to and authorize
_____ to perform a treatment of facial wrinkles with
Botox. _____
2. The nature and purpose of the treatment has been explained to me and questions I
have regarding the treatment have been answered to my satisfaction. _____
3. I understand surgery or other treatment alternatives may be as effective or more
effective in reducing the appearance of wrinkles. _____
4. I am fully aware of the risks of complications or injuries that can occur from this
treatment, both from know and unknown causes, and I freely assume those risks.

The known complications could include:

- Redness, swelling/edema, itching, pain or pressure lasting more than one week
- Nodules or induration at the injection site
- Discoloration of the injection site
- Poor effect
- Allergic reactions
- The effects of Botox are apparent 2-5 days after treatment
- The effects usually last 4-6 months. Periodic retreatment will be necessary to maintain the effects of Botox
- Repeated treatment may lead to permanent loss of muscle tone in the treated area
- Bruising
- Facial asymmetry
- Paralysis leading to droopy eyelid and double vision
- Some patients may experience weakness or flu-like symptoms

- Some patients may develop antibodies to Botox
5. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to Botox/Dysport. _____
6. I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained. _____
7. No guarantee, warranty or assurance has been made as to the treatment results

8. I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including: _____
- No laying down or reclining for four hours after injection
 - No scratching or rubbing the injected area
 - No bending forward for four hours
 - Make up should be avoided for one to two hours after injection
9. I agree to pay _____ for the above mentioned services. _____

Patient Name (please print) _____

Signature _____ Date _____

Witness Signature _____ Date _____

INFORMED PATIENT CONSENT FOR TREATMENT WITH INJECTABLE FILLERS

My signature and initials after each statement below constitutes my acknowledgment that:

1. I, _____, consent to and authorize _____ to perform with injectable fillers to improve the appearance of scars and/or wrinkles, or to have my lips augmented (made larger). The fillers to be used include Hylaform, Restylane, Collagen, and/or Juvederm.

- The area to be treated _____
- The filler to be used _____

2. The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction. _____

3. I am fully aware of the risks of complications or injuries that can occur from this treatment, both from know and unknown causes, and I freely assume those risks.

The known complications could include:

- Redness, swelling/edema, itching, pain or pressure lasting more than one week
- Nodules or induration at the injection site
- Discoloration of the injection site
- Poor effect or weak filling
- Allergic reactions

4. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to hyaluronic acid or bovine source collagen. _____

5. I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the

consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained. _____

6. No guarantee, warranty or assurance has been made as to the treatment results

7. I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including: _____

- Avoiding prolonged sun or UV exposure
- Avoiding saunas for two weeks after injection
- Avoiding steam baths for two weeks after injection
- Make up should be avoided for at least 12 hours after injection

8. I agree to pay _____ for the above mentioned services. _____

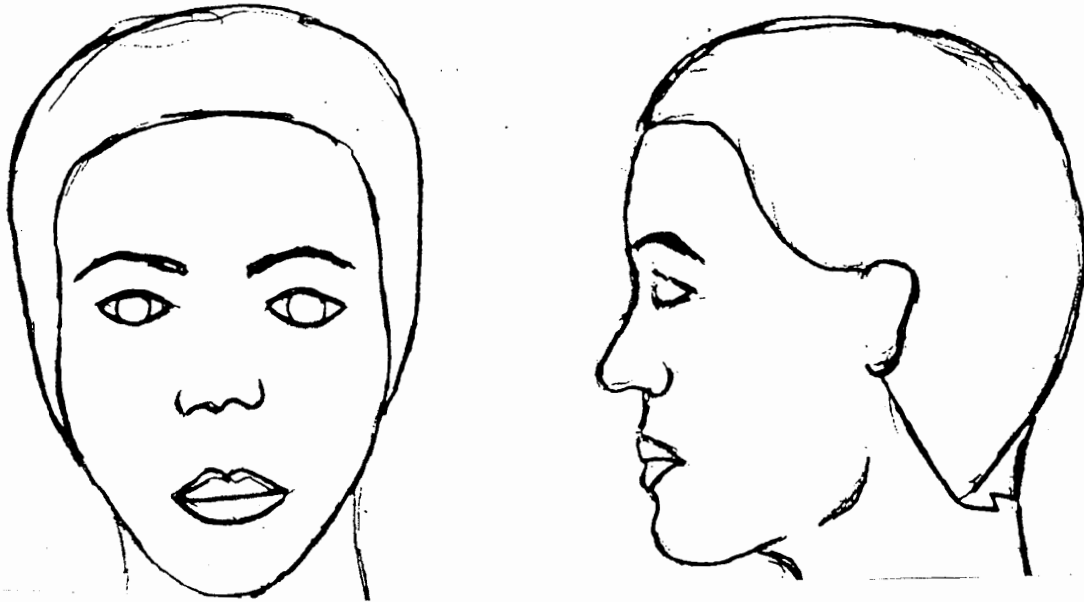
Patient Name (please print) _____

Signature _____ Date _____

Witness Signature _____ Date _____

Patient Treatment Chart for Botox and Fillers

Injection pattern



Initial Evaluation/date			Procedure/date			Comments
Areas to treat	Estimated Units	Estimated cost	Areas treated	Units used	Cost	
Provider Signature:			Provider Signature:			
Patient Signature:			Patient Signature:			
Filler: Captique/ Restilan						
Areas to treat			Vials	Cost	Comments	

Deposit: _____