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 ____

____

			IF YES, EXPLAIN
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 ahs 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 hyluronic 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 ahs 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. __________

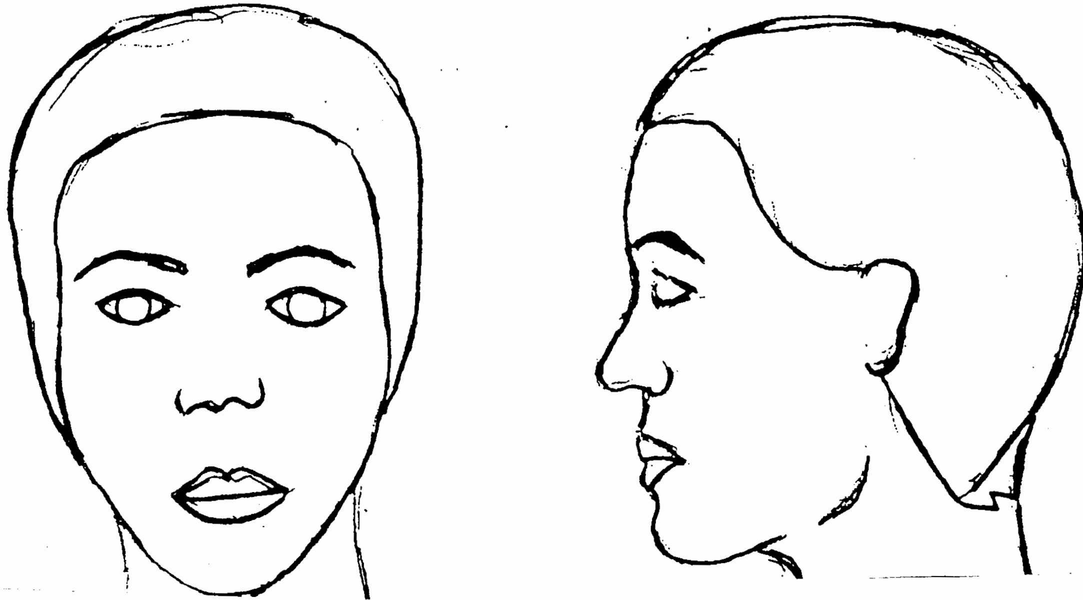
Patient Name (please print)____

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: ____