# PATIENT INFORMATION/MEDICAL HISTORY

Name:_____ Date:_____ Age:_____

Address:_____
Street City State Zip Code

Phone: Home:_____ Work:_____ Email_____

Date of Birth:_____ Marital Status:_____ SS#:_____

Employer:_____ Occupation:_____

Emergency Contact:_____ Relationship:_____
Phone: Home:_____ Work:_____ Cell:_____

## Health History

Medication (prescription and over the counter; vitamins, herbal medications)

_____

_____

_____

Allergies:_____

Surgeries/Dates:_____

_____

Have a History of?

| | | |
|---|---|---|
| __Heart Disease | __Mental Disease | __Neuro-muscular Disease |
| __Excessive Bleeding | __Auto-immune Disorders | __Diabetes |
| __High Blood Pressure | __Liver Disease | __Cold Sores/Fever Blisters |
| __Other | | |

_____

Are you? Pregnant_____ Nursing_____

Do you? Smoke_____ Drink Alcohol_____ Amount per day_____

*The above information is true and accurate to the best of my knowledge.*

_____ _____
Patient Signature Date

# RECORD OF COSMETIC CONSULTATION

Patient Name:_____ Date:_____

Reason for Consultation:_____

_____

_____

Cosmetic Diagnosis:_____

Recommendations/treatment plan:_____

_____

_____

_____

Contraindications to treatment:_____

_____

_____

Alternatives to treatment discussed:_____

_____

_____

Consultation by:_____RN

Reviewed/treatment plan approved by:_____MD

Referral to/Reason for referral:_____

# INFORMED CONSENT FOR THE TREATMENT OF FACIAL LINES /WRINKLES WITH BOTOX® Cosmetic

*You have the right to be informed about your skin condition & treatment so that you can make the decision whether or not to undergo the procedure after knowing the risks and benefits involved. This information is not meant to alarm you, but to better inform you so that you may give or withhold your consent for the treatment of your cosmetic condition as well as help you formulate additional questions which may not have been covered in consultation.*

Diagnosis: facial lines and/or wrinkles caused by aging, heredity, gravity, sun damage, muscle action, smoking or other factors; or a desire to sculpt the face by altering the contraction of targeted muscles. Muscles of facial expression can cause and worsen lines and wrinkles by intentionally making an expression. I request treatment with BOTOX® Cosmetic by Dr._____ _____or his/her designated medical licensed professional to treat lines/wrinkles in one, two or all of the following areas: forehead lines, frown lines and/or crow's feet and/or _____. The injection of BOTOX® Cosmetic for this purpose has been explained to me and my questions regarding such treatment, its alternatives, (such as dermabrasion, chemical peeling, laser resurfacing, dermal filler injections, face-lifting, brow lifting and other surgery, Retin-A, Renova or alpha hydroxy acids) its complications and risks have been answered by the doctor or his representative. The information given me has been in clear terms and I understand the risks and complications of the treatments. I understand that the FDA has approved BOTOX® Cosmetic only for the glabellar region and that injection into any area other than the glabellar area is considered off-label use. The treatment plan is to inject a small amount of BOTOX® Cosmetic, a purified neurotoxin produced by the Clostridium bacteria, into a targeted facial muscle to intentionally produce weakness or temporary paralysis of that muscle. This results in the relaxation of the muscle and improvement of the lines and wrinkles that the targeted muscle action produced or improved contour of the face. The response is usually seen in 2 to 6 days after injection. It is common for the muscle's action along with its associated wrinkles to return in 3 to 6 months. Repeat injections are necessary to maintain its effects. I understand that lines and wrinkles present at rest may not improve with treatment with BOTOX® Cosmetic alone, since BOTOX® Cosmetic is designed to treat lines caused by facial muscle action. Although results are frequently dramatic, as high as 10% of patients may not respond to these treatments for unknown reasons. I understand that the practice of medicine and surgery is not an exact science and that no guarantees can be or have been made concerning expected results in my case. Repeated sessions may be necessary in certain muscle groups to obtain the desired results. A charge will be made for each treatment session. Larger muscle groups require more BOTOX® Cosmetic and larger charges will be made according to the number of units of BOTOX® Cosmetic used. I may plan for multiple treatment sessions in the future, which are completely at my discretion as to the number, extent or amount. I understand that this is a cosmetic procedure and I will be completely responsible for all charges at the time of treatment. I understand that fewer facial expressions will be possible after my injections with Botox. I understand that I should stay upright and not lie down for 4 hours after injection. I will not massage the injected sites for at least 4 hours. I will contract the injected muscle for 1 hour after injection. Side effects of BOTOX® Cosmetic may include but are not limited to headache, bruising, pain during injection, asymmetry, twitching, and numbness and in a small number of cases, drooping of the eyelids or eyebrows. The injection may not work for as long or as well as expected. I am not pregnant, nursing or have any neurological diseases. If taking Amino glycoside antibiotics, Penicillin, Quinine, I understand that these medications may potentiate the effect of BOTOX® Cosmetic. I give permission for photographs taken of all treated sites to be used to document the medical record, teaching purposes, illustration of scientific papers or for use in lectures. My name shall not be used in such publication. I agree to follow up with Dr. _____ at his/her recommended intervals to assess my status and to inform him/her of any problem that I may be having and allow him/her to see me at that time. My questions have been fully answered and I have read or have had read to me this document, have not taken any medications which may impair my mental ability, do not feel rushed or under pressure and understand its contents. I hereby give my unrestricted informed consent for the procedure.

Patient Signature_____ Date_____

Witness Signature_____ Date_____

MD's Signature_____ Date_____

**Juvederm Patient Informed Consent to Treat**

**Patient Name:**_____ **Date:**_____

Injectable Juvederm Ultra and Juvederm Ultra Plus Implants are gels of hyaluronic acid generated by non animal protein. There is no necessity for skin testing prior to receiving Juvederm treatment, as allergic reaction is very unlikely. Juvederm is indicated for implantation into the mid to deep dermal layers of the skin in order to temporarily provide correction of moderate to severe facial wrinkles and folds. Juvederm has been shown to provide correction to the injected sites for up to 6 to 9 months; however, the correction does not last as long when used for lip augmentation. **Juvederm has not been studied for safety and effectiveness in any other anatomic regions other than naso-labial folds and is not FDA approved for any other sites other the nasal labial folds**. Juvederm should not be used by patients with severe allergies and with a history of anaphylaxis, pregnant or nursing, under the age of 18, in areas of active infection, or on immunosuppressive therapy.

The risks involved in receiving Juvederm injections include very temporary inflammation at injection site, demonstrated as redness, slight swelling, bruising, and tenderness and possibly itching. If laser treatment, chemical peeling or any other procedure based on active dermal response is considered after treatment, there is a possible risk of eliciting an inflammatory reaction at the implant site. Without touch up injections, the correction will subside gradually and your skin will look as it did before treatment. Patients using substances that reduce coagulation, such as aspirin and non-steroidal anti-inflammatory drugs may experience increased bleeding with resulting bruising at the injection sites. Other risks may include temporary local pain, redness, and itching, temporary skin discoloration, bruising and swelling in the treated area. Additional side effects are possible, but none have been observed or are known of at this time.

**You should contact your physician immediately should any unusual side effects occur.**

As with any injection procedure, there exists the risk of side effects. These risks have been explained to me in detail. I have read the above information and have had the procedure explained to me by my doctor or his representative. I understand the success of this procedure cannot be guaranteed and I am aware of the benefits and risks associated with this procedure. I give my consent to treatment with Juvederm by Dr. _____ _____ or his/her representative, _____ _____.

Patient Signature_____ Date_____

Witness Signature_____ Date_____

MD's Signature_____ Date_____