Botox Treatment

D'OR
BEAUTY & AESTHETICS CLINIC

Consultation Form

Personal Information :

DATE : _______________ DATE OF BIRTH : __________________ AGE: __________________

NAME : ____

GENDER : ☐ MALE ☐ FEMALE ☐ OTHER

CITY : ______________________ ZIP: _____________ STATE: ________________________

PHONE : _________________________ EMAIL: _______________________________________

PHONE #: _________________________ ADDRESS: _____________________________________

EMERGENCY CONTACT : ____

HOW DID YOU HEAR ABOUT US ? ____

Medical History

Do you currently or have you had any of the following? Please check all that apply:

○ **Hepatitis**	○ Radiation	○ Cardiac valve disease	○ Autoimmune Disorder
○ Glaucoma	○ Hemophilia	○ Mood altering disorder	○ Pregnant/Breastfeeding
○ Chemotherapy	○ Depression	○ Hypertrophic scarring/keloids	○ Serious heart condition
○ Aids/HIV	○ Diabetes	○ Bleeding disorder	○ History of MRSA
○ other	○ Other:	○ other	○ Cancer

Do you have any other allergies?

IF YES, LIST PLEASE: ____

Are you currently taking any medication? YES / NO

Are you pregnant ? YES/ NO

Have you had an injectable treatment recently? YES/ NO

Do you smoke? YES / NO

Any recent surgery, including plastic surgery ? YES/ NO

Are you claustrophobic? YES/ NO

Do you wear contact lenses? YES/ NO

BY SIGNING BELOW, I AGREE TO THE FOLLOWING:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that i do not have any condition(s) that would make the requested treatment unsuitable . I will inform the technician of any discomfort i may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

DATE: ______________ Signature: ______________

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Consent Form

PATIENT : ________________________________ D.O.B : ________________________________

ADDRESS: ________________________________ PHONE : ________________________________

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

The Treatment:

Botulinum toxin (Botox® and similar agents) is a neurotoxin produced by the bacterium Clostridium A. Botulinum toxin can relax the muscles on areas of the face and neck which cause wrinkles associated with facial expressions or facial pain. Treatment with botulinum toxin can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear. Areas most frequently treated are:

a) glabellar area of frown lines, located between the eyes;
b) crow's feet (lateral areas of the eyes);
c) forehead wrinkles;
d) radial lip lines (smokers lines),
e) head and neck muscles. Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results can last up to 3 months. With repeated treatments, the results may tend to last longer.

Initial ________________

Risks And Complication

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1.Post treatment discomfort, swelling, redness, and bruising, 2. Double vision, 3. A weakened tear duct, 4. Post treatment bacterial, and/or fungal infection requiring further treatment, 5. Allergic reaction, 6. Minor temporary droop of eyelid(s) in approximately 2% of injections, this usually lasts 2-3 weeks, 7. Occasional numbness of the forehead lasting up to 2-3 weeks, 8. Transient headache and 9. Flu-like symptoms may occur.

Initial ____________________

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Pregnancy, Allergies & Neurologic Disease :

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenis gravis, multiple sclerosis, lambert-eaton syndrome, amyotrophic lateral sclerosis (ALS), and parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin. Initial ___________

Alternative Procedure:

Alternatives to the procedures and options that I have volunteered for have been fully explained to me.
Initial _____________

Payment:

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment. Initial _______________

Right To Discontinue Treatment :

I understand that I have the right to discontinue treatment at any time. Initial _________________

Publicity Materials :

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications and presentations. During courses given by Common Sense Dentistry and/or The American Academy of Facial Esthetics (AAFE), I understand that photographs and video may be taken of me for educational and marketing purposes. I hold the AAFE harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.
Initial _______________________

Result:

I am aware that when small amounts of purified botulinum toxin are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2 – 10 days and usually lasts up to 3 months but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual and there are some individuals who do not respond at all. I understand that I will not be able to use the muscles injected as before while the injection is effective but that this will reverse after a period of months at which time re- treatment is appropriate. I understand that I must stay in the erect posture and that I must not manipulate the area (s) of the injections for the 2 hours post-injection period. Initial
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I understand this is an elective procedure and I hereby voluntarily consent to treatment with botulinum toxin injections for facial dynamic wrinkles, TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

____

Patient Name (Print) Patient Signature Date

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

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Doctor Name (Print) Doctor Signature Date

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