INTAKE FORM

Botox / Filler

PAGE ONE

GENERAL INFORMATION

Client Full Name

Date of Birth | Gender

Street Address

City

Zip Code | State

Email Address | Phone No.

EMERGENCY CONTACT

Name | Phone No.

How did you hear about us?

Please check if you have or have had any of the following medical conditions:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Epilepsy
- ☐ Asthma
- ☐ Autoimmue diseases
- ☐ Bleeding Disorders
- ☐ Thyroid Disorders
- ☐ Neuromuscular Disorders
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Keloid Scars
- ☐ Recurrent cold sores
- ☐ Herpes Simplex Virus
- ☐ Cancer (Specify type) .....
- ☐ Other medical conditions .....

CURRENT MEDICATIONS

Please list all current medications, including over-the-counter and supplements.

Are you currently pregnant or breastfeeding?

Do you have any allergies? If yes, please specify:

Have you undergone any previous surgeries or medical procedures? If yes, please specify:

Do you smoke? If yes, please specify the frequency:

Do you consume alcohol regularly?

Continued on next page

Email: doctoriglesiasmiamilakes@gmail.com Phone:305-381-5301 Website: www.LysetteIglesiasMD.com

INTAKE FORM

Botox / Filler

PAGE TWO

SKIN HISTORY

Have you received any previous cosmetic treatments (Botox, dermal fillers, chemical peels, etc.)? If yes, please specify:

Do you have a history of skin conditions (e.g., eczema, psoriasis)? If yes, please specify:

What are your sun exposure habits, and do you have a history of sunburns?

Do you have a history of recurrent herpes (cold sores)?

Do you use sunscreen regularly?

TREATMENT GOALS AND CONCERNS

What treatment(s) do you wish to undergo?

What are your areas of concern or dissatisfaction?

What are your expectations and desired outcomes from the treatment?

I acknowledge that the information provided in this form is accurate and complete. I understand that it is my responsibility to inform the healthcare provider of any changes to this information in the future.

I understand that the information provided in this form will be used by the healthcare provider to assess my suitability for the proposed treatment and to provide appropriate care. I consent to the use of this information for these purposes.

CLIENT NAME - PRINTED

CLIENT - SIGNATURE

DATE

LI Endocrinology

Email: doctoriglesiasmiamilakes@gmail.com Phone:305-381-5301 Website: www.LysetteIglesiasMD.com

Botulinum Toxin

CONSENT FORM

I, _____[Client's Full Name], hereby provide my informed consent to undergo Botulinum Toxin (Botox Cosmetics, Dysport, Xeomin, etc.) injections at [Lysette Iglesias MD], hereafter referred to as "the Provider." I acknowledge that Botox is a cosmetic procedure aimed at diminishing the appearance of wrinkles and fine lines by temporarily immobilizing facial muscles.

Details of the Procedure: The purpose of the Botox treatment is to diminish the appearance of wrinkles and fine lines in the designated areas. Botox will be administered to specific facial muscles using a fine needle, with injection sites determined based on the treatment plan discussed with the provider. I understand that the effects of Botox are temporary, typically lasting between 3 to 6 months, with full results becoming evident within two weeks post-treatment.

Potential Side Effects: I acknowledge the potential side effects associated with Botox injections, including but not limited to temporary bruising, swelling, or redness at the injection site, headaches, elevated or arched eyebrows, drooping of the eyelid or eyebrow, uneven smile, drooling, facial asymmetry, dry eyes or excessive tearing, temporary weakness or paralysis of nearby muscles, and increased sensitivity to sunlight.

Risks and Complications: I understand that while complications from Botox injections are rare, they may include infection at the injection site, scarring, spread of the toxin to nearby muscles causing unintended weakness or paralysis, swallowing and breathing difficulties, vision problems, double vision, dizziness, and rare but severe allergic reactions, including anaphylaxis.

Pregnancy and Breastfeeding Status: I confirm that I am not presently pregnant or breastfeeding. I am aware that Botox treatment is contraindicated during pregnancy or breastfeeding due to potential risks to the embryo, fetus, or infant.

Post-Treatment Care: I agree to adhere to the post-treatment care instructions provided by the Provider. The Provider has thoroughly explained post-treatment care, and I commit to following these instructions diligently.

CONSENT AND AGREEMENT

I consent to the taking of photographs of my face for personal use. These photographs will be used solely to document my treatment progress and for before-and-after comparisons. I understand that these photographs will be kept confidential and will not be shared or used for any other purposes without my explicit consent.

I have read and understand the information provided in this consent form. I have had the opportunity to ask questions and have received satisfactory answers. I consent to undergo Botox treatment with full knowledge of the potential risks, complications, and side effects.

CLIENT NAME - PRINTED

CLIENT - SIGNATURE

DATE

Email: doctoriglesiasmiamilakes@gmail.com **Phone:305-381-5301** **Website: www.LysetteIglesiasMD.com**

Endocrinology

CANCELLATION POLICY

In order to ensure the provision of high quality care in a reasonable time, an appointment and cancellation policy has been established. Since appointments are in high demand, canceling in advance allows us to assign the time to other clients who need immediate attention. This regulation contributes to improving the availability of appointments for all our clients. During your appointment booking, you will be asked to make a deposit of __$25.00__, which will be used as credit towards your scheduled treatments. We understand that situations may arise that require you to cancel or reschedule your appointment. To avoid problems, we ask that you give us at least 24 hours' notice. In these cases, your deposit will be refunded or applied to a later appointment. However, if you give less than 24 hours' notice, a cancellation fee of _$25.00__ will apply. Please note that if you arrive more than _15_ minutes late for your appointment, you will be considered a no-show and a cancellation fee will apply. We are available to answer any questions or concerns that may arise regarding our cancellation policy.

To establish contact, use our email address indicated below, avoid leaving a message on the recorder, because at the volume of the calls, it will not be heard.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by its terms. I agree to pay the cancellation fee if I miss an appointment.

CLIENT NAME - PRINTED

CLIENT - SIGNATURE

DATE

Email: doctoriglesiasmiamilakes@gmail.com Phone:305-381-5301 Website: www.LysetteIglesiasMD.com