ALL ABOUT MEDICINE

Patient Information & Medical History for Botox/Dermal Filler Treatment

Name: Date:

Address:

City: State: Zip:

Phone: (H) (W) (Cell)

E-mail: DOB: Age: sex: M/F

Did you have Botox and/or Dermal Filler before? Yes/no. If yes, did you have any adverse reactions? Yes/no. If yes, please explain:

Medical History (please circle yes or no, and explain below if yes)

Yes/no Do you currently have a active inflammation or infection in treatment area?

Yes/no Are you allergic to any of the ingredients in BOTOX@ Cosmetic (eg. Albumin/egg allergy)?

Yes/no Serious preexisting condition such as diabetes, congestive heart failure, uncompensated coronary artery disease, Rheumatoid arthritis, lupus or any other?

Yes/no Are you a blood donor?

yes/no Do you suffer from any diseases that affect your nerves and can cause a generalized impairment of muscle strength (i.e. myasthenia gravis, Eaton-Lambert syndrome)?

Yes/no Are you pregnant or planning to become pregnant soon; or currently breastfeeding?

Yes/no Are you currently taking antibiotics used to treat infections, such as gentamicin, tobramycin, clindamycin, and lincomycin?

Yes/no Are you currently taking steroids or non-steroidal anti-inflammatory drugs?

Yes/no Any medicines used to treat heart rhythm problems, such as quinidine; and anti-coagulants (coumadin)?

Yes/no Medicines used to treat different conditions, such as myasthenia gravis or Alzheimer [a]s

Yes/no disease?

Yes/no Any over-the-counter medicines or herbal products that may interfere with the treatment?

Yes/no Do you have any non-distensible scars or widened surgical scars?

Yes/no Do you have any actinic damage of lips?

Yes/no Previous serious reaction to hyaluronic acid derivatives?

Yes/no History of anaphylactic reactions or multiple severe

Yes/no allergies?

Yes/no Product specific contraindications?

Yes/no History of hypertrophic or keloid scars?

Do you have an important social function in next 72 hours?

Are you under the care of a physician? If yes, name and contact info:

If yes, please explain:

What are your expectations of this treatment?

Other current medications/supplements:

Other Current medical illness(es):

Known allergies to drugs/substances:

1 ATTEST THE ABOVE INFORMATION TO BE TRUE, R<OWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature Date:

Certification by Health Care Professional

I, hereby certify that:

- A discussion and explanation of BOTOX@ Cosmetic, Injectable Dermal Fillers and other non-invasive cosmetic procedures (the 'Procedure'), the KNOWN risks and benefits of the Procedure associated with this treatment, the alternatives to the Procedure and the risks and benefits of those alternatives have been thoroughly discussed with the client.

- The client has been asked if he/she has any questions regarding this treatment or the risks and those questions have been answered to the best of the healthcare professional's ability.

- The arrangements for post-treatment care have been discussed with the client who has agreed to the plan for post-procedural care.

It has been ascertained that the client fully understands the risks, benefits, and possible alternatives to the Procedure.

Name of physician: _____

Physician Signature: _____ Date:_____

Client Name: _____ Client Signature: _____

ALL ABOUT MEDICINE

Informed Consent for BOTULINUM TOXIN Type-A INJECTION

Please initial after each statement and sign at the bottom of page.

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

1. I,_____(full name), consent to and _____ authorize (name of company and/or practitioner) to perform a treatment to possibly reduce 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 full satisfaction. _____(initials).
3. I understand that surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles. _____(initials).

4. I am fully aware of the risks of complications, adverse reactions or injuries that can occur from this treatment, both from known and unknown causes, and I freely assume those risks. _____(initials).

The known complications may include:

- Redness, swelling/edema, itching, bruising, pain or pressure lasting over a week.
- Nodules or induration at the injection site.
- Discoloration of the injection site.
- Suboptimal result.
- Allergic reactions.
- Facial asymmetry.
- Paralysis leading to droopy eyelid and/or droopy eyebrow, and double vision.
- Weakness and/or flu-like symptoms.
- Development of antibodies to Botox.
- Permanent loss of muscle tone in the treated area with repetitive treatments.

5. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophic scars, a history of auto-immune disease, or immune therapy, or a muscular disease such as myasthenia gravis. I am not pregnant or breast-feeding, and I have no known allergy to albumin (egg-white) or Botox. _____(initials).

6. I certify that I have read this entire informed consent and that I understand and agree with 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 prior to 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. _____(initials).

7. No guarantee, warranty or assurance has been made as to the results of the treatment. _____(initials)

8. I understand that the results are usually apparent after 2-5 days, and that the results are of temporary nature (results usually last 3-6 months), and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions and posttreatment instructions, including:

   - No laying down or reclining for four hours after injection.
   - No scratching or rubbing the injected area.
   - No bending forward for four hours.
   - No make-up for one to two hours after injection.
   - Post-treatment exercises done every minute for 2 hours post-treatment.

9.I agree to pay the agreed upon fee for the above-mentioned services at the time of treatment. _____(initials)

Patient Name (please print): _____

Signature: _____ Date: _____

ALL ABOUT MEDICINE

Informed Consent for Treatment with INJECTABLE DERMAL FILLERS

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

I,_____(full name), consent to and _____ authorize Dr Amir Etemadnia to perform a treatment with injectable dermal filers to possibly improve the appearance of scars and/or wrinkles, or to have my lips or cheeks or any other areas augmented (made larger). The dermal fillers used include Collagen fillers, Juvederm, Restylane, Perlane, Radiesse, etc.

1. The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my full satisfaction. _____ (initials)

2. I understand that surgery or other treatment alternatives may be as effective or more effective in improving my appearance. _____ (initials).

3. I am fully aware of the risks of complications, adverse reactions or injuries that can occur from this treatment, both from known and unknown causes, and I freely assume those risks. _____(initials).

The known complications may include but not limited to:

- Redness, swelling/edema, itching, bruising, pain or pressure lasting over a week.
- Nodules or induration at the injection site.
- Discoloration of the injection site. • Poor effect/result or weak filling.
- Allergic reactions.
- Facial asymmetry.

4. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophic scars, a history of auto-immune disease, or immune

therapy. I am not pregnant or breast-feeding, and I have no known allergy to hyaluronic acid or bovine source collagen. _____ (initials)

5. I certify that I have read this entire informed consent and that I understand and agree with 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 prior to 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. _____ (initials).

6. No guarantee, warranty or assurance has been made as to the results of the treatment. _____(initials)

7. I understand that the results are of temporary nature (results usually last 3-12 months), and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions and post-treatment instructions, including:

   - Avoid prolonged sun or UV exposure.
   - Avoid saunas or steam baths for 2 weeks after injection.
   - No make-up for at least 12 hours after injection.
   - Continue to massage treatment area if indicated to prevent nodules.
   - No other cosmetic treatment directly over the dermal filler (e.g. laser).

8. I agree to pay the agreed upon fee for the above-mentioned services at the time of treatment. _____ (initials).

Patient Name (please print):

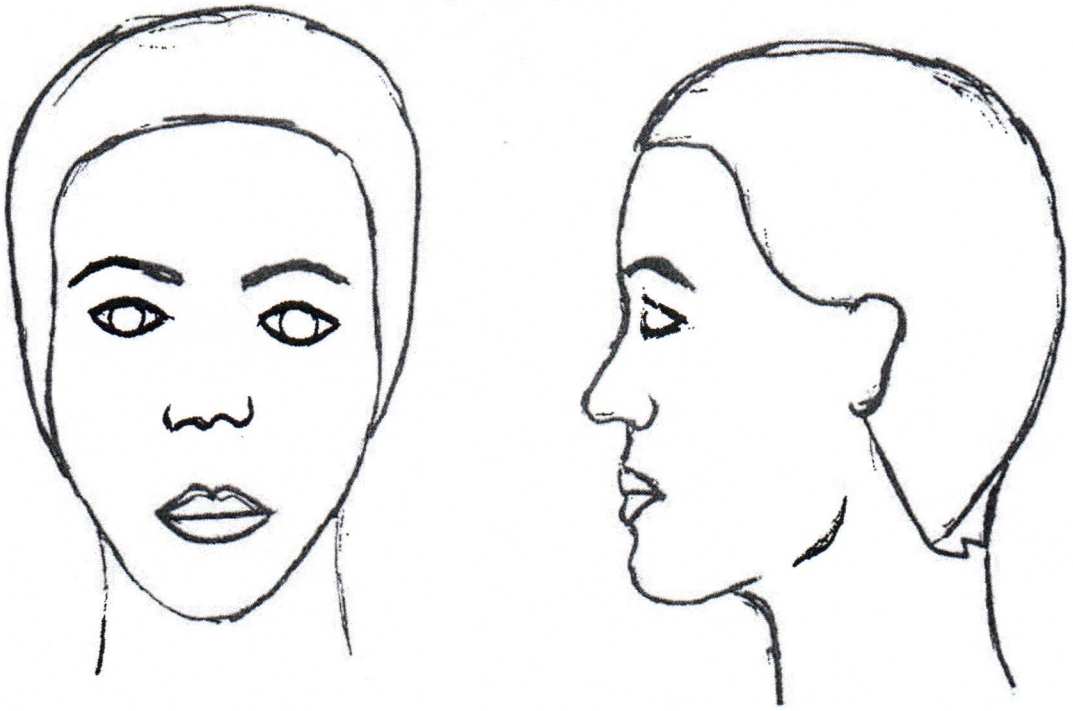
_____

Signature:

_____ _____

Patient Treatment Chart for Botox & Filler

Injection pattern



Date

_____

BOTOX FILLER

Areas Treated	Units Used	Areas Treated	Amount Used
Glabella		Naso-labial	
Frontlis		Lips	
Crows Feet		Cheeks	
Other		Other	

Patient Signature

_____

Provider Signature

_____

Time In: _____

Time Out:_____