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____

Requested Area of Treatment:

BOTOX Filler

Frown lines (between the eyes)_______________ Lip Augmentation_____________________

Horizontal forehead lines____________________ Nasolabial folds_______________________

Crow's Feet______________________________ Marionette Lines______________________

Bunny lines (bridge of nose)_________________ Vertical lip lines_______________________

Droopy Eyebrow________________________ Scar fill-in___________________________

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 ALLERGAN) between the patient and

Tri-State Progressive Health 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

* Visual problems

* Dry Eyes

* 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 has been made as to the treatment results __________

8. I will hold Tri-State Progressive Health, it's owner[s], agents, employees and shareholders completely harmless from all and any litigation or claims made should I have any adverse reaction to Botox® or reaction to Botox®. Further, I hold all injectors completely harmless from any and all litigation, malpractice suits or claims made in relation to my receiving Botox®. Tri-State Progressive Health, have the right to limit the amount of Botox ® someone will be given in the session.

9. If you are planning a LASIK® procedure, please inform the injector as your Botox® may be deferred.

10. 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

This agreement is non-transferable and may not be altered by anyone without the express written consent of Tri-State Progressive Health. Further, this agreement does not expire.

Patient Name (please print)____

Signature_____________________________________ Date_________________

Witness Signature ______________________________Date__________________

INFORMED CONSENT FOR TREATMENT WITH INJECTABLE FILLERS BETWEEN

THE PATIENT AND TRI-STATE PROGRESSIVE HEALTH

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

12. 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____

13. 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. __________

14. 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

* In extremely rare cases, skin necrosis or "death of skin" may occur as a result of injection into a blood

vessel. This may result in financial costs, extended care and scar formation.

15. 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, Vascular disease, HIV disease, immune therapy or psychiatric disease. I am not pregnant, breast-feeding, and I have no known allergy to Hyaluronic acid, anesthetic agents, latex gloves [should they be used] or bovine source collagen. __________

16. 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 all reasonable attempts to maintain complete confidentiality of my name will be maintained. Tri-State Progressive health maintains the right not to treat minors even with adult consent.

17. Furthermore, I completely and totally indemnify Tri-State Progressive Health, its owner[s], agents, employees, shareholders and

[independent] contractor's from any and all liability in relation to the performance of this procedure[s

18. No guarantee, warranty or assurance HAVE been made as to the treatment results __________

19. 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

Tri-State Progressive Health maintain the right to defer treatment on any patient should it be in either of

their opinion's that any treatment or further treatment is not warranted.

This agreement is binding. It may not be modified by the person receiving the injections or by anyone else without the express written approval by Tri-State Progressive Health that any modifications are allowed. This agreement does not expire.

Patient Name (please print)____

Signature____________________________________ Date_________________

Witness Signature _____________________________Date__________________

Patient Treatment Chart for Botox & Filler

Injection pattern

Date________________

BOTOX

Areas Treated Units Used

1. Glabellar ___________
2. Frontalis ___________
3. Crows Feet ___________
4. ______________ ___________

Total Areas Treated: _______

Total Units Used:______

BOTOX Lot No.___________

Patient Signature____

Provider Signature____

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