PATIENT INFORMATION AND MEDICAL HISTORY

Name: _____SSN: _____- _____-_____
Full Address: _____City_____State____Zip_____
Cell Phone: _____ Alternate Phone: _____
Date of Birth: / / 19 Age: ____ Email: _____

HISTORY – Please circle if you have or have had :

Have you taken **accutane** in the past six months? Yes/No

Are you under the care of a physician? If yes, name: _____

Current/Recent medications: _____

Medical illness_____

IF YES, EXPLAIN _____

Diabetes
Herpes – cold sores
Heart problems or family history of heart problems?
Photosensitive disorder
Autoimmune illness of any type (example: lupus or other)
History of Bell's Palsy
Keloid scars Yes No
Hypersensitivity to skin products Yes No
Skin infections Yes No
Photo sensitizing substances Yes No
Laser work of any type Yes No
Complications from botulinum/fillers/lasers? Yes No
Are you pregnant or breastfeeding? Yes / No
Allergies of any kind, including anesthetics, lidocaine, drugs or gram-positive bacteria_____

Have you had any cosmetic work done in past? Fillers/botox/plastic surgery_____

Areas of interest for liquid facelift/laser treatment: _____

circle area of interest below:

Skincare: **skin care regimen you are currently using: _____**
Wrinkles: **lines on forehead, between eyebrows, around eyes, droopy brow-tail to be lifted**
Healthy Skin: **red vessels/brown spots on face/chest/hands to be lightened – glowy luminous clear skin desired**
Eyelashes: **longer, thicker, fuller eyelashes / eyebrows**
Skin texture: **wrinkles, large pores, textural irregularities, scars, acne pitting scars, stretch marks to be smoothed out**
Under eyes: **appearance of hollows or bags under eyes to be improved**
Skin tightening: **areas of excess laxity to be tightened on face, jowls, neck, décolletage, chest, arms, cellulite, thighs**
Body contouring: **areas of resistant excess fat to be shrunken?**
Varicose veins: **varicose veins on the legs to be treated?**
Fillers: **hollowed temples, hollows under eyes, flat cheekbones, flat mid-face, thinned lips, deflated lower face to be Contoured**

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.
FOR THE SERVICES RECEIVED TODAY, I AGREE TO PAY $_____.

Per credit card merchant agreement, I agree to pay the above amount to my credit card. I understand that payment for services rendered is due at time of service. In the event of default, I promise to pay legal interest on the indebtedness, along with collection costs, and any reasonable attorney fees required to effect collection of this note.

Adult Signature_____ Date_____

OVER >

INFORMED BOTULINUM TOXIN INJECTION

(botulinum toxin type-A commercially sold as "Botox™" or " Xeomin™" or "Dysport™")

FOR THE TEMPORARY TREATMENT OF SUPERFICIAL FACIAL WRINKLES

Please initial after each statement and sign at the bottom.

Botulinum toxin works by paralyzing nerves and muscles.

1. I, _____, consent to and authorize Dr. Anouche Moshari-Roberts to perform a treatment of facial/neck wrinkles with botulinum A sold as described above. _____ **(initial)**
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. _____ **(initial)**
3. I understand surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles. _____ **(initial)**
4. I am fully aware of the risks of complications of injuries that can occur from this treatment, both from known and unknown causes, and I freely assume those risks. _____ **(initial)**

The known complications could include:
- Redness, swelling/edema, itching, bruising, pain or pressure lasting more than one week
- Nodules or induration at the site of injection
- Discoloration of the injection site
- Minimal effect requiring additional doses; poor effect, or no effect at all
- The effects of botulinum toxin are apparent from 4 to 14 days after treatment
- The effects usually last an average of 3 months. Periodic retreatment will be necessary to maintain the effects

Common side effects include, but are not limited to:
- Allergic reactions
- Facial asymmetry
- Paralysis leading to droopy eyelid and double vision
- Some patients may experience weakness, flu-like symptoms, or headache
- Some patients may develop antibodies to the botulinum toxin
- Botulinum toxin may migrate to areas away from site of injection
- Botulinum toxin may cause difficulty breathing or swallowing - hours to weeks post injection requiring emergent medical attention. _____ **(initial)**

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, or allergy to albumin. I am not pregnant, am not breast-feeding, and I have no known allergy to botulinum type A. _____ **(initial)**
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. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. _____ **(initial)**
7. No guarantee, warranty or assurance has been made as to the treatment results. There are no refunds.
8. If the treatment is unsatisfactory, I will return to the office to be seen no later than 14 days post injection. I pay per unit received. _____ **(initial)**
9. 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 face down, reclining for four hours after injection. No scratching or rubbing the injected area
- No bending forward, no yoga, no facials, no face massages, no exercising for 24 hours
- Make up should be avoided for one to two hours after injection _____**(initial)**

Patient Name (please print) _____
Signature_____Date _____

Signature_____Date _____

Signature_____Date _____

Signature_____Date _____