Botulinum Toxin

Personal Information

Name: First_____ Middle_____ Last_____
Birth Date_____-_____-_____. Phone #_____
Address_____
City/State/Zip_____
Email _____
How did you hear about our office? _____

Treatment Check-In

Are you currently under treatment with a healthcare provider? (if yes, please explain)
_____
What was your most recent cosmetic treatment? (please indicate if this is your first cosmetic treatment with botulinum toxin)
_____

Person/Company who provided previous treatments? _____
Date of Last treatment _____ Have you ever fainted during or after procedures? _____
Have you ever had a cosmetic procedure you did not like the outcome of? (If yes, please explain)
_____

Have you ever had Rhinoplasty? Y or N
Are you allergic to Eggs? Y or N
Are you allergic to Lidocaine? Y or N
Do you have any allergies, or can you think of something you've had an adverse reaction to? _____

Please list all current medications, dose, and length you've been taking the medication.
_____
_____

Are you pregnant? Yes or No Are you breastfeeding? Yes or No

Skin History – Do you have or have you ever had:

Keloid Scars Y or N
Hives Y or N
Skin Cancer Y or N
Waxing Y or N
Electrolysis Y or N
Cold sores Y or N
Hypersensitivity to skin products Y or N
Skin Infections Y or N
Tanning within the past 6 weeks Y or N
Laser Skin resurfacing Y or N
Chemical Peels Y or N
Photo-sensitizing substances Y or N
Antibiotic, Diuretics, Blood pressure medicine are all examples of photosensitizing substances. _____
Additional Information you would like to share? _____

Areas of interest today? _____

Agree & Sign

I attest the above information to be true, knowing my practitioner(s) rely on this information to provide the most safe and effective treatment.

Signature_____ Date_____

Informed consent for Botulinum Toxin

I, _____(name), consent to and authorize Dr. David F. Simmons, DC, FNP-C to provide botulinum toxin as an elective procedure to improve general aesthetic appearance.

_____Dr. David F. Simmons, DC, FNP-C, maintains the right to defer or refuse treatment on any person should it be either of their opinions that any treatment, or future treatments is not warranted.

_____I am fully aware of the risks of complications or injuries that can occur from the treatment through the use of botulinum toxin, both from known and unknown causes, and I freely assume those risks. Known complications could include the following:

1. Redness, swelling/edema, itching, pain, pressure lasting more than 1 week.
2. Nodules/induration at the injection site. Discoloration of the injection site, poor effect
3. Allergic reactions
4. The effects of botulinum toxin appear two to five days after treatment and can take up to 2 weeks for the full effect.
5. The effects of botulinum can last for up to 3 to 4 months.
6. Repeated treatments may lead to permanent loss of muscle tone in the treated areas and some patients my develop antibodies to botulinum toxin.
7. Bruising, fascial asymmetry, temporal paralysis leading to droopy eyelid and double vision, weakness or flu-like symptoms, visual problems & dry eyes.

_____The nature and purpose of the above elective treatment(s) has been explained to me and my questions have been answered to my situations.
_____I understand surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles.
_____I have not received any cosmetic injections within the last two weeks.
_____I certify that I do not have any of the known conditions that would contraindicate treatment. These include hypertrophic scars, a history of autoimmune disease, vascular disease, HIV, Aids, immune therapy, psychiatric disease.
_____I am not pregnant. I am not breast feeding.
_____I have no allergies to latex gloves (should they be used)
_____NO guarantee, warranty, or assurances have been made regarding the treatment results.
_____I understand that due to the nature of medical aesthetics single or multiple treatments may be required for desired effects.
_____I understand that the results are temporary and subsequent or future treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including:

1. Avoid prolonged sun or UV exposure.
2. Avoid saunas for 2 weeks after injection.
3. Avoid steam baths for 2 weeks after injection.
4. Makeup should be avoided for at least 12 hours after injection.
5. Remain upright for minimum of 4 hours after treatment.
6. Do not touch or apply pressure to or around injection sites for 24 hours to prevent botulinum toxin from moving into unwanted areas.

_____This agreement is binding, non-transferable and may not be altered by anyone without the expressed written consent of Dr. David F. Simmons, DC, FNP-C. Further, this agreement does not expire.
_____I completely understand, and total indemnify Dr. David F. Simmons, DC, FNP-C and/or his associated entity/s, owners, agents, employees, shareholders, & independent contractors from any and all liability in relation to the performance of the procedure(s) and consequences of the products.
_____I agree to pay Dr. David F. Simmons, DC, FNP-C for the product injected at time of service.
_____I certify that I have read this entire informed consent and that I understand and agree to the information stated on 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.
_____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 (unless I've provided permission) and all reasonable attempts to maintain confidentiality will be made.

Signature

_____ **Date**_____