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 _____
Hepatitis _____
Herpes _____
Menopause _____
Sensitive to anesthetic _____
Lupus _____

Irregular menses _____
Heart problems _____
Hysterectomy _____
Hypertension _____
Photosensitive Disorder _____
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

Frown lines (between the eyes)_____
Horizontal forehead lines_____
Crow's Feet_____
Bunny lines (bridge of nose)_____
Droopy Eyebrow_____

Filler

Lip Augmentation_____
Nasolabial folds_____
Marionette Lines_____
Vertical lip lines_____
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)

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®. _____

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 Grace Health Services completely harmless from all and any litigation or claims made should I have any adverse reaction to the Botox injections. Any and all complications should be seen in the emergency room or by your local physician. Any subsequent care or corrections would be at your own cost.

9. If you are planning a LASIK procedure, please inform the provider 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 Grace Health Services. Further, this agreement does not expire.

11. I agree to pay for the above mentioned services.

Patient Name (please print)_____

Signature_____ Date_____

Witness Signature_____ Date _____

BOTOX® Cosmetic onabotulinumtoxinA injection

BOTOX® COSMETIC PATIENT TREATMENT RECORD

Customize treatment with the *ART* of Assessment®

PATIENT NAME

CHART/IDENTIFICATION NUMBER

TREATMENT DATE

AESTHETIC PROVIDER

LOT NUMBER

EXPIRATION DATE

TREATMENT DATE

AESTHETIC PROVIDER

LOT NUMBER

EXPIRATION DATE

TREATMENT DATE

AESTHETIC PROVIDER

LOT NUMBER

EXPIRATION DATE

BOTOX® Cosmetic (onabotulinumtoxinA)

Indications

BOTOX® Cosmetic is indicated in adult patients for the temporary improvement in the appearance of:

- moderate to severe glabellar lines associated with corrugator and/or procerus muscle activity
- moderate to severe lateral canthal lines associated with orbicularis oculi activity
- moderate to severe forehead lines associated with frontalis activity

IMPORTANT SAFETY INFORMATION, INCLUDING BOXED WARNING

WARNING: DISTANT SPREAD OF TOXIN EFFECT

Postmarketing reports indicate that the effects of BOTOX® Cosmetic and all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These may include asthenia, generalized muscle weakness, diplopia, ptosis, dysphagia, dysphonia, dysarthria, urinary incontinence and breathing difficulties. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults treated for spasticity and other conditions, particularly in those patients who have an underlying condition that would predispose them to these symptoms. In unapproved uses, including spasticity in children, and in approved indications, cases of spread of effect have been reported at doses comparable to those used to treat cervical dystonia and spasticity and at lower doses.

CONTRAINDICATIONS

BOTOX® Cosmetic is contraindicated in the presence of infection at the proposed injection site(s) and in individuals with known hypersensitivity to any botulinum toxin preparation or to any of the components in the formulation.

Please see additional Important Safety Information on reverse side.

Compliments of Allergan.

INFORMED CONSENT FOR TREATMENT WITH INJECTABLE FILLERS

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, Restalyne, 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. Grace Health Services maintains the right not to treat minors even with adult consent.

17. Furthermore, I completely and totally indemnify Grace Health Services from any and all liability in relation to the performance and consequence of this procedure(s). Any clinical follow-up and or corrections would have to be done at my own cost with the practitioner of my own choosing. Any and all concerns should first be seen in the local emergency room.

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

Grace Health Services maintain the right to defer treatment on any person should it be in either of their opinion 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 of Grace Health Services. This agreement does not expire.

20. I agree to pay _____ for the above mentioned services _____

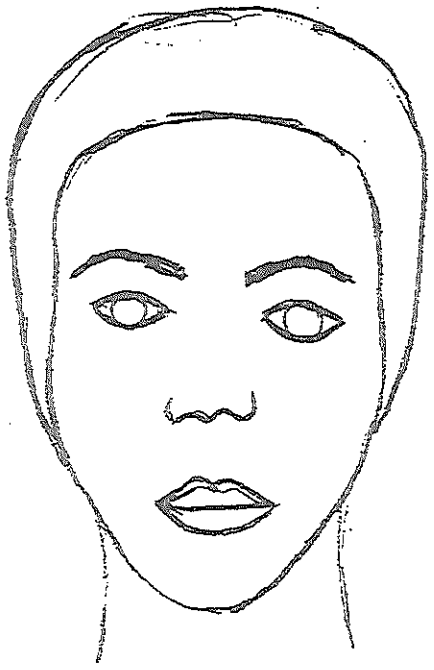
Patient name (please print)_____

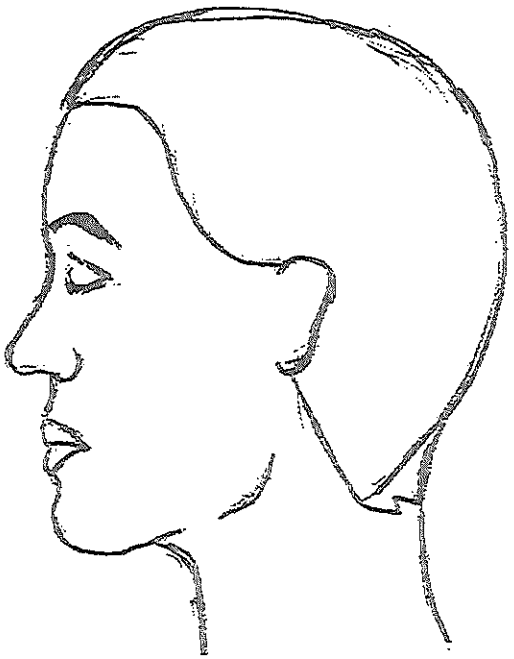
Signature _____ Date _____

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. _____	_____

FILLER

Areas Treated	Amount Used
1. Lips	_____
2. Nasolabial	_____
3. Oral Commissures	_____
4. _____	_____

Total Areas Treated: _____

Total Units Used:_____

Total Amount Used_____

BOTOX Lot No._____

Patient Signature_____

Provider Signature_____

_____

_____

Method of Payment

□ Cash

□ Check payable to Aesthetic Medical Educators Training enclosed

□ Charge to: _____Mastercard _____Visa _____AmExpress _____Discover

Card Number _____

Exp Date _____

CVC Code _____

Billing Address _____

Signature _____