

Aspire Dental

BRANDON M HALL DDS

Name _____ Address _____
City _____ State _____ Zip _____
Home Phone _____ Work/Cell Phone _____
Primary Physician's Name _____ Phone# _____
DOB _____ Age _____ Ht _____ Wt _____
Please list all the medications you are currently taking: _____

Allergies: _____ Are you on antibiotics at the time: _____

Please Circle any of the following illnesses you have or have ever had in the past:

- | | | | |
|-------------------|---------------------|------------------------|-------------------------------|
| Myesthenia Gravis | Hepatitis | Eye Disease | Autoimmune Disease |
| Numbness | Parkinson's Disease | Neurological Disorders | Lambert-Eaton Syndrome |
| Vision Problems | Muscle Weakness | Multiple Sclerosis | Amyotrophic Lateral Sclerosis |

List and/or explain other Medical Conditions not listed; or any muscle dysfunction:

Previous Hospitalizations/Operation: _____

WOMEN: Are you pregnant, trying to get pregnant, or nursing? _____

Have you had plastic surgery or other surgery to your face/neck areas when? _____

Had Botox Injections before: _____ Last Treatment? _____ what areas? _____
_____ Were you happy with previous Botox treatments? _____
Explain _____

Have you ever had eyelid/eyebrow droop after Botox? _____
Do you show a lot of upper eyelid when eyes are open? _____
Do your eyelids feel heavy when you don't get enough sleep? _____
Do your eyelids droop without sleep? _____
Areas of special concern? _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any error or omissions that I have made in the completion of this form.

Patient Signature _____ Date _____



Pre-Treatment Instructions

In an Ideal situation it is prudent to follow some simple guidelines before treatment that can make all the **difference between a fair result and a great result**, by reducing some possible side effects associated with the injections. We realize this is not always possible; however, minimizing these risks is always desirable.

- Do not schedule if you are pregnant, trying to get pregnant, or nursing.
- **Avoid Alcoholic beverages** at least 24 hours prior to treatment (Alcohol may thin the blood increasing risk of bruising).
- Do not schedule if you have known muscle disease, neurologic disorder, or eye disease.
- **Avoid Anti-inflammatory/ Blood thinning medications** ideally, for a period of two (2) weeks before treatment. Medications and supplements such as Aspirin, Vitamin E, Gingo Biloba, St. John's Wart, Ibuprofen, Motrin, Advil, Aleve, Vioxx, and other NSAIDS are blood thinning and can increase the risk of bruising/swelling after injections.
- **Schedule Botox appointment at least 2 weeks prior to a special event, which may be occurring, i.e., wedding, vacation, etc. etc.**

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Consent to Botox Treatment

Botox a neurotoxin produced by the bacterium Clostridium A. Botox can relax the muscles on areas of the face and neck, which cause wrinkles associated with facial expressions. Treatment with Botox can cause your facial expression lines or wrinkles to essentially disappear. Areas most frequently treated are a) glabellar area of frown lines, located between the eyes; b) crow's feet (lateral areas of the eyes); and c) forehead wrinkles. Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Clients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results last 3-6 months. With repeated treatments, the results may tend to last longer.

Risks and Complications

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1. Post treatment discomfort, swelling, redness, and bruising, 2. Double Vision 3. Rarely weakened tear duct 5. Post treatment bacterial, and/or fungal infection requiring further treatment 6. Allergic reaction 7. Minor temporary droop of eyelids in approximately 2% of injections, this usually last 2-3 weeks. 8. Occasional numbness of the forehead lasting up to 2-3 weeks, 9. Transient headache, and 10. Flu-like symptoms may occur.

Photographs

I authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand my identity will be protected.

Pregnancy, Allergies & Neurological Disease

I am not aware that I am pregnant and I am not trying to get pregnant, I am not nursing, have any significant Neurological disease including but not limited to Myasthenis Gravis, Multiple Sclerosis, Lambert Eaton Syndrome, Amyotrophic Lateral Sclerosis(ALS), Parkinson's or that I have any allergies to the toxin ingredients, or to human albumin.

Payment

I understand that this is an "elective" cosmetic procedure and that payment is my responsibility.

Results

I am aware that when small amounts of purified botulinum (BOTOX) are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2-10 days and usually last 3-6 months but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactory or for as long as usual and there are some individuals who don't respond at all. I understand that I will not be able to "frown" while the injection is effective but that this will reverse after a period of months at which time re-treatment is appropriate. I understand that I must stay in erect posture and that I must not manipulate the are(s) of the injections for 2 hours post-injection period.

I understand that this in an elective procedure and I hereby voluntarily consent to treatment with Botox injection for the condition known as : Facial Dynamic Wrinkles. The procedure has been fully explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the office immediately.

Patient Name

Patient Signature

Date

Witness Name

Witness Signature

Date