

Facial Art Institute LLC

Contact Information

Name: _____ Date of Birth: ___/___/___ Social Security #: ___ - ___ - ___

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: (____) _____ Alternate Phone: (____) _____ Email: _____

Emergency Contact: _____ Phone: _____

Medical History

Please circle any of the following that you have or have had:

High blood pressure

Keloid scarring

Liver disease

Diabetes

Lung disease

Herpes

Stroke

Kidney disease

AIDS/HIV

Heart Disease

Thyroid disease

Hormonal disorders

GERD

Cancer

Very dry skin

Neuromuscular disease

Headaches

Bleeding disorder

Do you wear contacts/glasses? _____ Use Accutane? _____ Use photosensitizing medications? _____ Use immunosuppressive medications? _____ Have an active infection? _____

Please list all surgical procedures: _____

Please list all medications, including over the counter and supplements: _____

Do you have a reaction to any type of medication or contact with any substance? _____

Please list any family medical problems: _____

Medical History Continued

Please circle any of the following symptoms you have or have had in the past year:

- Fever, chills, night sweats, weight loss, appetite change, fatigue, weakness
- Bleeding gums, nosebleeds, easy bruising
- Seizures, migraines, headaches, depression, anxiety, insomnia, memory loss, dizziness, slurred speech
- Sinus problems, hoarseness, cough, shortness of breath, bloody cough, wheezing
- Chest pain/discomfort, palpitations, difficulty breathing, fainting, hand/ankle swelling
- Difficulty swallowing, heartburn, abdominal pain, nausea, vomiting, diarrhea, constipation, rectal bleeding, black stools
- Pain with urination, blood in urine, frequency, urgency, hesitancy
- Joint pain/swelling/stiffness, muscle aches, limitation in range of motion
- Skin rash/ulcers/dyscoloration, varicose veins, spider veins

Age of first menstrual period: _____ Number of pregnancies: _____ Live births: _____

Date of last Well Woman exam: _____ abnormal pap smear: _____

When were you last exposed to the sun (include tanning booth): _____

Do you use chemical tanning lotion? _____

Please circle which skin type best describes you (exposed to sun for 1 hour without protection):

- Always burns, never tans
- Always burns, sometimes tans
- Sometimes burns, sometimes tans
- Always tans
- Hispanic, Asian, Mediterranean, Middle Eastern, African American

Social History

Occupation: _____ Marital Status: _____ Regular Exercise: _____

Smoking history: _____ Alcohol: _____ Caffeine: _____

How did you hear about our services? _____

Facial Art Institute LLC

Financial Policy

It is our policy that all prepayments/payments for services are nonrefundable and nontransferable. We understand that circumstances beyond your control may arise which would prevent you from ever starting or completing your treatment. In these cases, we will evaluate these circumstances on an individual basis. Products and services are to be redeemed within one year of this dated contract or all prepayments are forfeited.

Photography Authorization

We will use photographs for comparative purposes before and after certain treatments. These photos are to be used solely for the purposes stated above and are not to be published for any reason unless proper consent from the patient is obtained and discussed.

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

Consent for Neurotoxin

Patient Name: _____ Date: _____

To the patient: You have the right to be informed about your skin condition and treatment so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is simply an effort to better inform you so that you may give or withhold your consent from this treatment program.

I have requested this attempt to improve my facial expression lines with neurotoxin. These injections have been used for more than a decade in children and adults to improve the problem of muscle spasm of the facial muscles. This toxin has also been useful to correct double vision due to muscle imbalance. Injections of minute amounts weaken the muscle and prevent frowning, crow's feet, and expression lines. Although the results are usually dramatic, I have been informed that the practice of medicine is not an exact science and that no guarantees can, or have been made concerning expected results in my case.

Initial if true _____

The solution is injected with a small needle into the muscle. You see the benefits develop over the next 5-7 days, with full benefits at 14 days. Less frowning will be possible.

Initial if true _____

Side effects and complications are usually minimal. Occasionally, slight swelling and/or bruising may last for several days after the injection. I have been advised of the risk in such treatments, the expected benefits of such treatments, and alternative treatment, including no treatment at all.

Initial if true _____

I understand the most significant risk could be a drooping brow or eyelid, or weakness in the muscle that closes the eye, if adjacent muscles are affected by the injection. This will usually resolve after several weeks.

Initial if true _____

I understand that the injection of neurotoxin is temporary, but that after multiple injections there may be permanent effects.

Initial if true _____

I understand more than one injection may be needed to achieve a satisfactory result.

Initial if true _____

I understand the contraindications to this treatment include pregnancy, bleeding disorders, neuromuscular disorders, significant cardiovascular disorders, and allergies to albumin (egg) products. I understand the contraindications and I possess none of these conditions.

Initial if true _____

I understand that funds paid are non-refundable.

Initial if true _____

I agree that this constitutes full disclosure and it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions.

Initial if true _____

FIRST PROCEDURE

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

SECOND PROCEDURE

I have re-read and understand the consent above. If I have questions, they have been answered to my satisfaction.

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

THIRD PROCEDURE

I have re-read and understand the consent above. If I have questions, they have been answered to my satisfaction.

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

FOURTH PROCEDURE

I have re-read and understand the consent above. If I have questions, they have been answered to my satisfaction.

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

FIFTH PROCEDURE

I have re-read and understand the consent above. If I have questions, they have been answered to my satisfaction.

Patient Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

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Post Injection Instructions for Neurotoxin

What to Expect:

1. You will start to see results 3-5 days after injection with maximum results in two weeks. Please allow two full weeks to appreciate the results and to determine if more treatment is needed.
2. Treatment may last 3 months or more. They may be repeated after this timeframe. Over time, the muscles will be retrained and less frequent treatments may be required.

Do Not:

1. Do not rub or scratch area where the Neurotoxin was injected, which may cause migration of the Neurotoxin out of the desired are.
2. Do not exercise for at least 4 hours after injections. (walking is acceptable)
3. Do not lie flat for at least 4 hours after injections.
4. Do not drink alcohol or take non-steroidal medicine such as ibuprofen or aspirin for at least 4 hours after injections.

Do:

1. Sit up for at least 4 hours.
2. Accentuate the movement in your face that was treated with the Neurotoxin.
3. Enjoy your fresh new look and say thank you to all compliments.