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	_____	Irregular menses	_____
Hepatitis	_____	Heart problems	_____
Herpes	_____	Hysterectomy	_____
Menopause	_____	Hypertension	_____
Sensitive to anesthetic	_____	Photosensitive Disorder	_____
Lupus	_____	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_____

Type of treatment requested Botox/ Filler _____

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 ALERGAN)

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 known 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
- 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 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

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

Patient Name (please print)_____

Signature_____ Date_____

Witness Signature _____Date_____

SUEDE SURGICAL CARE, LLC

HIPPA PRIVACY RESTRICTION QUESTIONNAIRE

PATIENT NAME _____ DOB _____

MAY WE CALL YOUR HOME: YES / NO MAY WE CALL YOUR WORK: YES / NO

IF NO, PROVIDE AN ALTERNATE NUMBER: _(_____)_____

MAY WE SEND YOU A FAX: YES / NO FAX #: _(_____)_____

MAY WE CONTACT YOU VIA EMAIL: YES / NO EMAIL ADDRESS: _____

MAY WE LEAVE MESSAGES (INCLUDING LAB RESULTS) ON YOUR ANSWERING MACHINE/VOICEMAIL YES / NO

MAY WE SPEAK TO ANOTHER FAMILY MEMBER REGARDING YOUR TREATMENT YES / NO

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

FOR MINORS: CALL MOTHER ONLY / CALL FATHER ONLY / CALL EITHER PARENT

NAME OF CHILDREN THAT APPLY TO THESE RESTRICTIONS:

_____ _____

_____ _____

CONSENT AND ACKNOWLEDGEMENT

I consent to the use or disclosure of my protected health information by Suede Surgical Care, LLC to any person or organization for the purpose of carrying out treatment, obtaining payment or conducting certain health care operations. Protected health information used or disclosed by Suede Surgical Care, LLC may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used to disclose in accordance with the Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how Suede Surgical Care, LLC will use and disclose my information can be found of the Notice of Privacy Practices. I understand that this consent is effective for as long as Suede Surgical Care, LLC maintains my protected health information. By signing below, I understand and acknowledge the following:

- I have read and understand this consent, and
- I have received a copy of the Notice of Privacy Practices currently in effect.

_____ _____ _____

NAME SIGNATURE DATE

If signed by a person of legal representation, please describe your legal authority to act on behalf of the individual.

Describe _____

Signature _____ Date _____

BOTOX/Dermal Filler Pre-Treatment Instructions

BOTOX:

*To reduce risk of bleeding and bruising **avoid** the following for **2 days prior** to treatment:*

- Alcoholic beverages
- Anti-inflammatories
- Aspirin
- Vitamin E
- Ginkgo Biloba

Dermal Filler:

*To reduce risk of bleeding and bruising **avoid** the following for **2 days prior** to treatment:*

- Alcoholic beverages
- Anti-inflammatories
- Aspirin
- Vitamin E
- Ginkgo Biloba
- If you have a history of oral herpes simplex, you should be pre-treated prior to the procedure