

Kathy Aronson, RN

2516 Samaritan Dr. Suite N San Jose CA 95124

(408) 507-5351

Bradley A. Greene, MD A Professional Corporation

NAME _____ DOB ____/____/____ AGE _____

SEX M F MARITAL STATUS _____ SPOUSE _____

ADDRESS _____ CITY _____ ZIP CODE _____

PLEASE INDICATE YOUR PREFERRED METHOD(S) OF CONTACT:

MOBILE ____ - _____ HOME ____ - _____ WORK ____ - _____

EMPLOYER _____ OCCUPATION _____

E-MAIL ADDRESS _____

REFERRED BY _____

EMERGENCY CONTACT _____

RELATIONSHIP TO PATIENT _____ PHONE ____ - _____

DRUG ALLERGIES/SENSITIVITIES _____

By signing below, I agree and consent to receive medical care and/or treatment by Kathy Aronson, RN

I understand that I am responsible for payment of my account in full.

SIGNATURE OF PATIENT _____ DATE _____

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Patient History

PATIENT NAME _____

TO OUR PATIENTS: IT IS OUR PLEASURE TO BE OF SERVICE TO YOU. WE WOULD APPRECAITE YOUR ANSWERING A FEW MEDICAL QUESTIONS THAT MAY RELATE TO THE PROCEDURE YOU ARE CONSIDERING.

YES NO Do you have any drug allergies? Please list: _____

YES NO Do you take aspirin or aspirin related products? _____

YES NO Are you taking any medication including diet pills, vitamins, or herbs? Please list all

Medications _____

YES NO Have you had any previous operations including plastic surgery?

YES NO Have you ever been hospitalized for anything other than surgery?

YES NO Are you currently being treated for any medical conditions?

YES NO Do you have any history of bleeding or bleeding tendencies?

YES NO Have you ever had a blood transfusion?

YES NO Do you smoke, or have you smoked in the past 3 years?

YES NO Do you drink alcohol?

YES NO If you are a female patient is there any possibility you may be pregnant?

When was your last menstrual cycle? _____

YES NO Do you have a history of poor or bad scarring?

PATIENT SIGNATURE _____ DATE _____

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Botox® Cosmetic (Botulinum Toxin Type A) & **Dysport®** (abobotulinumtoxin A) **CONSENT**

Botox® and Dysport® are neuromuscular blocking agents indicated for temporary improvement in the appearance of moderate to severe wrinkles.

How quickly does Botox® / Dysport® work and how long does it last? The full effects should occur within 2 weeks, although some patients will see more rapid onset. Some areas will not become fully relaxed with one treatment and may need a touch up or multiple treatments over time to achieve the desired effect. Over the next 3 - 6 months, the effect will gradually fade and the muscle function will return. A simple repeat treatment is all that is required to maintain the desired result.

What side effects can occur?

- One in ten patients will develop a small bruise or hematoma, which can take up to several weeks to resolve. Aspirin, ibuprofen, alcoholic beverages, fish oil or vitamin E supplements can increase the chance of bruising.
- Even with proper injection technique, some patients will experience drooping (ptosis) of the eyebrow or eyelid. This can last 2-3 months.
- Double vision (diplopia) has been reported. This can last 2-3 months.
- Botox® and Dysport® may cause a slight eyebrow lift at the arch of your eyebrow.
- You may notice a slight change in the shape of the eye. This can last 2-3 months.
- Headache, dry mouth, muscle pain and nausea have been reported.

Contraindications: If any of the following apply, you should not receive Botox®/ Dysport® injections:

- If you are now pregnant or breast-feeding.
- Have a disease that affects your muscles and nerves, such as amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), myasthenia gravis or Lambert-Eaton syndrome.
- Have an allergy to botulinum toxin or abobotulinum toxin
- Have a skin infection at the planned injection site.
- Have an allergy to human albumin.

Please initial your understanding and consent to the following:

_____ The treated areas will take 1 to 2 weeks to soften. Occasionally, the desired effect is not achieved with the first treatment and a touch-up is necessary. Touch-up treatments cost the same per unit, but the amount of Botox®/ Dysport® needed is typically ¼ to ½ the amount used in the initial treatment. **You should wait 14 days before scheduling a touch-up treatment.**

_____ As with any injection, patients who are using substances that can prolong bleeding, such as aspirin, ibuprofen, fish oil or vitamin E supplements may experience increased bruising or bleeding at injection site.

_____ The goal of Botox® and Dysport®, as in any cosmetic procedure, is aesthetic improvement and not perfection. You may be dissatisfied with the results.

I verify that I have had the opportunity to ask questions regarding this treatment and I have had my questions answered to my satisfaction.

Signed: _____ **Print:** _____ **Date:** _____

Witness: _____ **Print:** _____ **Date:** _____

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Dermal Fillers Consent

Restylane® and Juvederm® dermal fillers are all non-animal, stabilized and colorless hyaluronic acid gels that are injected into facial tissue. Hyaluronic acid is a naturally occurring sugar found in the human body. The role of hyaluronic acid in the skin is to deliver nutrients, hydrate the skin by holding in water and to act as a cushioning agent. The results generally last about three to nine months.

Contraindications for treatment with Dermal Fillers:

- Patients with severe allergies marked by a history of anaphylaxis or history or presence of multiple severe allergies.
- Dermal Fillers should be used with caution in patients on immunosuppressive therapy, or therapy used to decrease the body's immune response, as there may be increased risk of infection.
- The safety of Restylane® and Juvederm® dermal fillers for use during pregnancy has not been established.
- The safety of Restylane® and Juvederm® dermal fillers in patients with a history of excessive scarring (e.g. hypertrophic scarring and keloid formations) and pigmentation disorders has not been studied.
- If you have previously suffered from facial cold sores, there is a risk that the needle punctures could contribute to another occurrence. Speak to your Practitioner about medications that may minimize a recurrence.

As with any medical procedure, you should be aware of the safety issues and restrictions associated with this treatment.

Please initial your understanding and consent to the following statements:

_____ As with any injection procedure, there are risks of infection, lumpiness, redness, swelling pain, itching, discoloration or tenderness at the implant site. Typically, resolution is within 5-7 days after the injection. Some tenderness and swelling at the site may last for up to 2 weeks depending on the area treated.

_____ Patients who are using substances that can prolong bleeding, such as aspirin or ibuprofen, as with any injection, may experience increased bruising or bleeding at the injection site.

_____ Accidental Injection into a Blood Vessel: I understand that any dermal filler can be accidentally injected into a blood vessel, which may block the blood vessel and cause local tissue damage (necrosis) as well as subsequent sloughing of the skin and scarring near the injection site. It is usually reversible but may require treatment. In rare cases, injection into a blood vessel may also result in heart attack, stroke or blindness.

_____ Dermal fillers contain Lidocaine, which is a numbing agent to help improve patient comfort during injections. You confirm that you are not allergic to Lidocaine.

_____ The safety of Restylane® and Juvederm® dermal fillers for use during pregnancy has not been established. You confirm that you are not currently pregnant.

_____ Within 24 hours after treatment, you should avoid strenuous exercise, extensive heat or sun exposure and alcoholic beverages.

_____ Tell your Practitioner about any plans for laser treatment, chemical peels or any other facial procedure you may be planning to have within 2 weeks after treatment. Certain laser or chemical peels may increase an inflammatory reaction at the injection site.

_____ The goal of dermal fillers, as in any cosmetic procedure, is aesthetic improvement and not perfection. You may

be dissatisfied with the results or with the duration of the results.

_____ You agree and understand that this treatment is an elective procedure for cosmetic purposes only; it is not medically necessary and payment for the procedure is due at time of treatment. No third will be billed or held responsible for any portion of the cost of this cosmetic procedure.

_____ I verify that I have had the opportunity to ask questions regarding this treatment and I have had my questions answered to my satisfaction. I consent to being treated with Dermal Fillers and I agree with and understand the statements initialed above.

Signed: _____ Print: _____ Date: _____

Witness: _____ Print: _____ Date: _____