

FACIAL AESTHETIC and THERAPEUTIC MEDICAL HISTORY

In order to provide you with the most appropriate treatment, please complete the following questionnaire.

PERSONAL INFORMATION

Client Name:

Today's Date:

Date of Birth:

Age:

Occupation:

Home Address:

City:

State:

Zip:

Home Phone:

Cell Phone:

Email Address:

What is the best number for you to receive a follow up call this evening?

Emergency

Emergency

Contact Name:

Phone:

How were you referred to us?

MEDICAL HISTORY

YES NO

Are you currently under the care of a physician?

If yes, for what?

Do you have any of the following medical conditions? (Please mark YES or NO to all)

Y	N	Conditions	Y	N	Conditions
		High Blood Pressure			Hormone imbalance
		Heart Conditions			Any active infection
		Blood Clotting Abnormalities			Are you pregnant or trying to get pregnant"
		Diabetes			Are you using contraception?
		Arthritis			Are you breastfeeding?
		Cancer-Chemotherapy			Birth control pills
		HIV + AIDS			Neurologic disease
		Hepatitis A or B or C			Myasthenia Graves
		Seizure Disorder			Lambert-Eaton Syndrome
		Herpes			Parkinson's
		Frequent cold sores			Multiple Sclerosis (MS)
		Keloid scarring			Amuotrophic Lateral Sclerosis (ALS)
		Skin lesions			Fainting problems
		Skin disease			Pschiatric problems
		Thyroid imbalance			Headaches or Migranes

Do you have any disease, disorder or problems not listed above that the doctor should know about or that you are currently being treated for? If YES, please describe. YES NO

What oral prescription medications are you presently taking?

What antibiotics do you use to treat infections?

Are you presently taking any of the following medication or supplements listed below?

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
		Aspirin			Blood thinners			Hormones
		Mood altering medication			Anti-depression medication			Vitamin E
		Fish oil			Omega 3 fatty acids			Ginkgo biloba
		Garlic			Ginger			Cayenne
		Licorice			Flax seed oil			COQ10

Have you ever had an allergic reaction to the following?

Food

Eggs

Animal Protein

Latex

Aspirin

Hydroquinone or skin bleaching agents

Lidocaine (Anesthetic)

Hydrocortisone

Any other Allergies? Please list:

FACIAL HISTORY

What bothers you most about your facial appearance?

What are your expectations for today's visit?

Do you regularly sunbathe or use tanning salons? YES NO How often?

What topical medications or creams are you currently using? Retin-A other

(please list):

Have you waxed, tweezed, bleached or used hair removal cream within the last week? YES NO

If yes please specify:

Have you ever had Botox or dermal fillers? YES NO If yes, when were you last treated:

Any complications? YES NO If yes please specify:

Have you taken any Aspirin, Ibuprofen, Motrin, Tylenol, fish oil, Vitamin D, blood thinners, or alcoholic beverages in the last 10 days? YES NO

If yes what?

FACIAL INJURY TRAUMA HISTORY

Is there any history of facial surgery? YES NO

Describe:

is there any recent history of trauma to the head or face? YES NO

Describe:

Any TMJ problems? YES NO

Describe:

BRILLIANT DISTINCTIONS

Are you currently enrolled in the Brilliant Distinctions Program? YES NO

If yes, please provide us with your member number:

If not, Brilliant Distinctions is a program that rewards you with savings on Allergen facial treatments including products like Botox®, Juvederm and SkinMedica Skin Care. Ask us for details on how to sign up.

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: _____

Date: _____

FACIAL AESTHETIC SELF ASSESSMENT

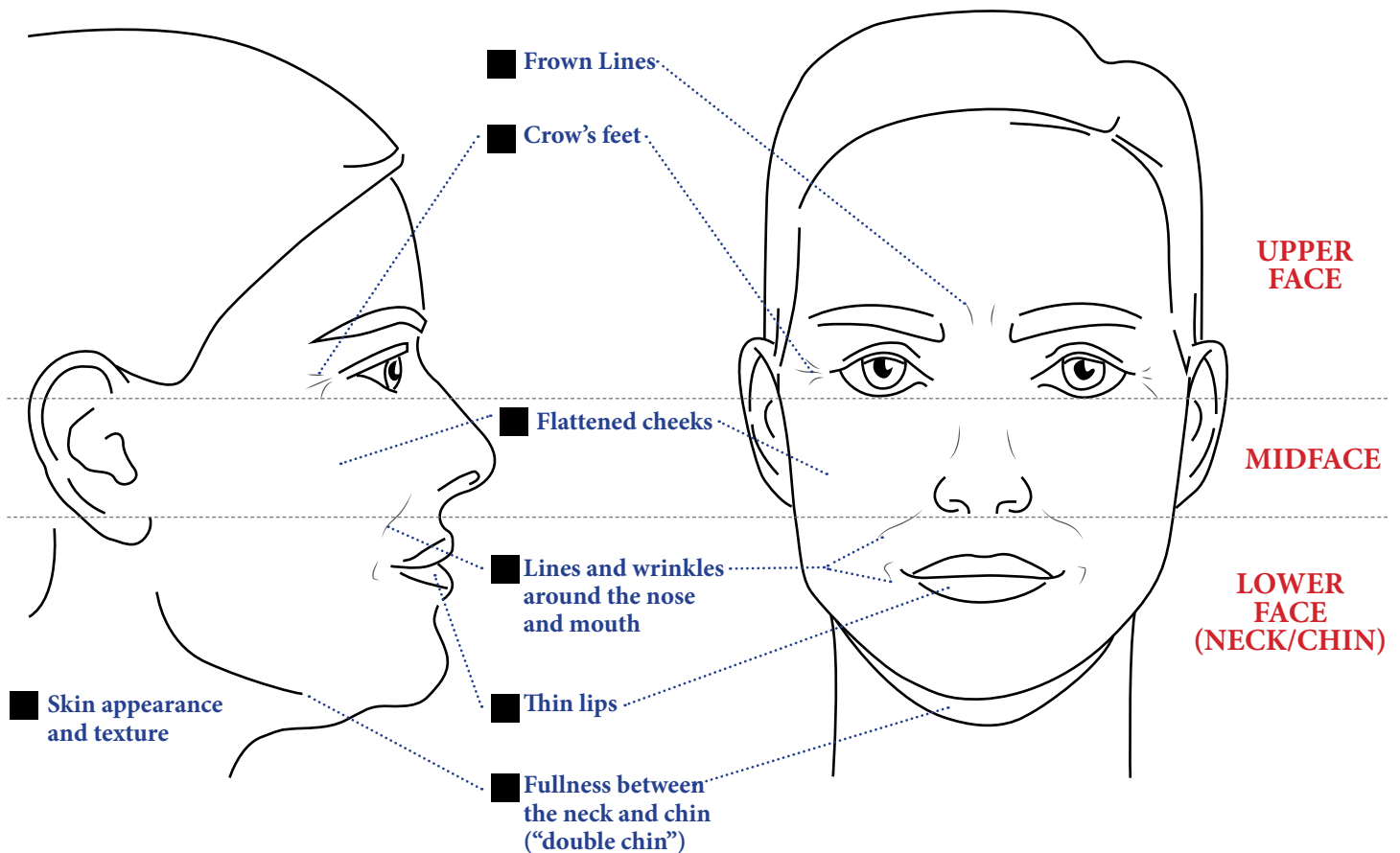
At our Health Inspired Dental Office, we know there is more to a great smile... Therefore we offer Botox®, dermal fillers, and other facial aesthetic services that compliment your smile.

Name:

Date:

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Please check below if you are interested in therapeutic uses of Botox® in dentistry:

- | | |
|---|--|
| <input type="checkbox"/> Temporomandibular joint disorder (TMJ) | <input type="checkbox"/> Gummy smile (high lip line) |
| <input type="checkbox"/> Bruxism or grinding | <input type="checkbox"/> Black triangles or spaces between teeth |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Masseteric Hypertrophy (increased size of facial muscles) |

6151 Wilson Mills Road, Suite 300
Highland Heights, Ohio 44143
Phone: 440-446-9417

INFORMED CONSENT FOR BOTULINUM TOXIN TREATMENT

Patient's Name: First: Middle: Last: Date of Birth:

Street Address: Phone:

City: State: Zip:

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/healthcare provider. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your doctor/healthcare professional prior to signing the consent form.

THE TREATMENT

Botulinum toxin (Botox®, Xeomin or Dysport) is a neurotoxin produced by the bacterium *Clostridium A*. Botulinum toxin can relax the muscles on areas of the face and neck which cause wrinkles associated with facial expressions or facial pain. Treatment with botulinum toxin can cause your facial expression lines or wrinkles to be less noticeable or 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); c) forehead wrinkles; d) radial lip lines (smokers lines), e) head and neck muscles. Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results can last up to 3 months. With repeated treatments, the results may tend to last longer.

Initial:

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. 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. A weakened tear duct, 4. Post treatment bacterial, and/or fungal infection requiring further treatment, 5. Allergic reaction, 6. Minor temporary droop of eyelid(s) in approximately 2% of injections, this usually lasts 2-3 weeks, 7. Occasional numbness of the forehead lasting up to 2-3 weeks, 8. Transient headache and 9. Flu-like symptoms may occur.

Initial:

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenis gravis, multiple sclerosis, lambert-eaton syndrome, amyotrophic lateral sclerosis (ALS), and parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin.

Initial:

ALTERNATIVE PROCEDURES

Alternatives to the procedures and options that I have volunteered for have been fully explained to me.

Initial:

INFORMED CONSENT FOR BOTULINUM TOXIN TREATMENT

(continued)

PAYMENT

I understand that this is an "elective" procedure and that payment is my responsibility and is expected at the time of treatment.

Initial: _____

I understand that I have the right to discontinue treatment at any time.

Initial: _____

PUBLICITY MATERIALS

I authorize the taking of clinical photographs and videos and their use for scientific and marketing purposes both in publications, presentations and marketing purposes. I hold Dr. Claudia Minadeo-Fox, D.D.S. harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

Initial: _____

RESULTS

I am aware that when small amounts of purified botulinum toxin are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2 – 10 days and usually lasts up to 3 months but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual and there are some individuals who do not respond at all. I understand that I will not be able to use the muscles injected as before 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 the erect posture and that I must not manipulate the area (s) of the injections for the 4 hours post-injection period.

Initial: _____

I understand this is an elective procedure and I hereby voluntarily consent to treatment with botulinum toxin injections for facial dynamic wrinkles, TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. 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 doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

Health History Completed? Yes No Date: _____ Doctor Initial: _____

Dental / Head and Neck Examination Completed? Yes No Date: _____ Doctor Initial: _____

Patient Name: (Print) Patient Signature: _____ Date: _____

I am the treating doctor/healthcare professional. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Doctor Name (Print) Doctor Signature Date
Dr. Claudia Minadeo- Fox _____ _____

Dr. Claudia Minadeo-Fox, D.D.S.
Health Inspired Dentistry
Botox 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 or 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.

- Patient must be in good health. A full medical and dental history is necessary on all patients for optimal results. Patient must not be pregnant, breast feeding or have a neurological condition like Myasthenia Gravis, ELS or ALS.
- Eat a small meal/snack before the injection. Some people can become light headed during an injection because the individual has not eaten to maintain a normal blood glucose level.
- If you develop a cold sore, blemish, or rash, etc. prior to your appointment in the injection area, your appointment should be rescheduled. Let us know if you are prone to cold sores – a pre-operative medication may help prevent cold sores after treatment.
- Avoid alcoholic beverages at least 24 hours prior to treatment. Alcohol may thin the blood which will increase the risk of bruising.
- AVOID: Anti-inflammatory and blood thinning medications ideally for 2 weeks prior to treatment (for example: Aspirin, Motrin, Aleve, Advil, Ginkgo Biloba, St. John's Wart, CoQ10, Garlic, Flax Oil, Cod Liver Oil, Fish Oil, Vitamin A, Vitamin E). which can increase your chance of bruising and swelling after the procedure. If you have a body ache or headache it is ok to take Tylenol.
- Discontinue Retin-A two (2) days before and two (2) days after treatment.
- Schedule your appointment 2 weeks or more prior to a special event or vacation should bruising occur.

Dr. Claudia Minadeo-Fox, D.D.S.
Health Inspired Dentistry
Botox POST TREATMENT INSTRUCTIONS

The guidelines to follow post treatment have been followed for years, and are still employed today for optimal results and to prevent and minimize the possible side effects associated with injections such as ptosis (drooping of the eyelids).

- No straining, bending over, heavy lifting or vigorous exercise for 4 hours following treatment. It takes the toxin several hours to bind itself to the nerve to start its work. If circulation is increased to that area it may wash away the Botox® from where it was injected.
- Avoid manipulation of the area(s) and keep head elevated for 4 hours following treatment. Don't lay down, rub or touch your face. Avoid wearing a hat (For the same reasons listed above.) Also avoid doing a facial, peel, micro-dermabrasion or massage for 48 to 72 hours after treatment with Botox®.
- It can take 10 days for the effects of treatment to be seen. The full effect varies on the individual but most can see full results in 8 days. Don't love it or hate it for 2 weeks, (results are best evaluated at week 2 through week 4), therefore, we invite our clients to come back for an assessment during this time period to determine the need for any enhancements.
- Arnica tablets or cream may be used to minimize bruising and speed up healing. Arnica Montana is a herbal over the counter medication that is proven through research to help healing. You can purchase these tablets or cream at a drug store or vitamin shop.
- Avoid alcoholic beverages and blood thinning medications at least 24 to 48 hours after treatment. This will reduce the incidence of bruising. If you have a body ache or headache it is ok to take Tylenol.
- It is best to wear no makeup or lipstick until the next day. Earlier use can increase the chance of infection at the injection sites.
- It is normal to see some bruising or swelling around the area that was injected today, and it may possibly last 1 to 2 weeks.

I certify that I have been counseled in post-treatment instructions and have been given written instructions as well.

Patient Signature:

Date:

6151 Wilson Mills Road, Suite 300
Highland Heights, Ohio 44143
Phone: 440-446-9417

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy policies, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 12/16/14, and will remain in effective until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information disclosed on this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients' Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of our best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonable believe you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed in this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you for each page, for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed in this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (email), you are entitled to receive this Notice in written form.

Questions and Complaints: If you want more information about our privacy practices or have questions or concerns, please contact us.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:

Relationship to Patient:

(If under 18, parent or guardian signature is required)

Signature:

(If under 18, Parent or Guardian Signature Required)

Date: