HOUMA FAMILY
DENTAL

NEW CLIENT HISTORY

First Name: _____ Date: _____

Last Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email: _____ Occupation: _____

How did you hear about us? _____

MEDICAL HISTORY

Do you have any chronic medical conditions we should know about?	Yes	No
If so, please list: _____		
Do you have any allergies to latex, medications, herbal or natural supplements?	Yes	No
If so, please list: _____		
Do you have, or have you had, any changes in medical history recently?	Yes	No
Please list any and all current/past surgeries or surgical procedures. _____		
_____		
Have you taken Accutane within the past year?	Yes	No
Are you on any anticoagulants, daily Aspirin, Motrin, or Advil?	Yes	No
Are you a smoker?	Yes	No
Do you have veneers on your teeth?	Yes	No

WOMEN ONLY:		
Are you pregnant?	Yes	No
Are you currently breast-feeding?	Yes	No
Are your menstrual cycles normal?	Yes	No

Additional information you would like your technician to know: _____

_____

Client Signature: _____ Date: _____

Witness: _____ Date: _____

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CLIENTS RIGHTS AND RESPONSIBILITES

We are committed to serving you with compassion, care, and respect. As one of our valued clients you are entitled to the following:

You have the right:

- To be treated with respect and dignity.
- To know the names and professional status of the person(s) serving you.
- To privacy and confidentially.
- To receive accurate information about your health-related concerns.
- To know the effectiveness and potential side effects of all forms of treatment.
- To participate in choosing the form of treatment best suited to your skin.
- To review education and counseling about treatments.
- To review your medical record with you clinician.
- To amend your records.
- To receive any information about potential services or related services.

You have the responsibility:

- To seek medical attention promptly, and to provide useful feedback.
- To be honest about your medical history.
- To ask questions about anything you do not understand.
- To follow health advice and instructions.
- To report any significant changes in your health.
- To show up to appointments or cancel 48 hours in advance.

I authorize Houma Family Dental to perform the treatment or procedures recommended. I acknowledge no guarantee; either expressed or implied has been made to me regarding the outcome of any treatment or process.

I fully understand that it is impossible for anyone to make a guarantee regarding the outcome of any medical treatments or procedures.

I authorize the release of information to a licensed physician of the facility's choosing for the purpose of professional interpretation and establishment of the recommendations.

Client Signature: _____ Date: _____

Reviewed by: _____ Date: _____

HOUMA FAMILY
DENTAL

Botunlinum Toxin Type A: Botox® Cosmetic & Dysport® Consent Form

BOTOX Cosmetic is indicated for the temporary improvement in the appearance of moderate to server glabellar lines associated with corrugator and/or procerus muscles activity in adult patients ≤ 65 years or age.

BOTOX® Cosmetic (onabotulinumtoxinA) for injection, is a sterile, vacuum-dried purified botumlinum toxin type A, produced from fermentation of Hall strain Clostridium botulinum type A grown in a medium containing casein hydrolysate, glucose, and yeast extract, intended for intramuscular use. BOTOX® Cosmetic blocks neuromuscular transmission by binding to acceptor sites on motor nerve terminals, entering the nerve terminals, and inhibiting he release of acetylcholine. This inhibition occurs as the neurotoxin cleaves SNAP-25, a protein integral to the intramuscularly at therapeutic doses, BOTOX® Cosmetic procedures partial chemical denervation of the muscle resulting in a localized reduction in muscle activity.

Administration of BOTOX® Cosmetic is not recommended during pregnancy. There are no adequate and well-controlled studies or BOTOX® Cosmetic in pregnant women, it is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when BOTOX® Cosmetic is administered to a nursing woman.
DYSPORT™(abobotulinumtoxinA) is an acetylcholine release inhibitor and a neuromuscular blocking agent indicated for the temporary improvement in the appearance of moderate to server glabellar lines associated with procerus and corrugator muscle activity in adult patients ≤ 65 years of age.

The effects of DYSPORT™ and all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults, particularly in those patients who have underlying conditions that would predispose them to these symptoms.

DYSPORT™is contraindicated in patients with known hypersensitivity to any botulinum toxin preparation or to any of the components in the formulation. The product may contain trace amounts of cow's protein. Patients known to be allergic to cow's milk protein should not be treated with DYSPORT™. DYSPORT™ is contraindicated for use in patients with infection at the proposed injection site(s).

There are no adequate and well-controlled studies in pregnant women. DYSPORT™ should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is not known whether DYSPORT™ is excreted in human milk.

HOUMA FAMILY
DENTAL

Dermal Fillers: Consent Form

A. PURPOSE & BACKGROUND

As my patient, you have requested my administration of Dermal Filler; used in the correction of moderate to severe facial wrinkles and folds. All medical and cosmetic procedures carry risks and may cause complications. The purpose of this document is to make you aware of the nature of the procedure and its risks in advance so that you can decide whether to proceed with the procedure.

B. PROCEDURE

1. This product is administrated via syringe, or injection, into the areas of the face sough to be filled with dermal filler to eliminate or reduce the wrinkles and folds.
2. As anesthesia, numbing medicine used to reduce the discomfort of the injection, may or may not be used.
3. The treatment site(s) is washed first with an antiseptic (cleansing) solution.
4. Dermal fillers are to be injected under your skin into the tissue of your face using a thin gauge needle.
5. The depth of the injections will depend on the depth of the wrinkles and their location.
6. Multiple injections may be made depending on the site, depth of the wrinkle and technique used.
7. Following each injection, the injector should gently massage the correction site to conform to the contour of the surrounding tissues.
8. If the treated area is swollen directly after the injection, ice may be applied on the site for a short period.
9. After the first treatment, additional treatments may be necessary to achieve the desired level of correction.
10. Periodic touch-up injections help sustain desired level of correction.

C. RISK/DISCOMFORT

1. Although a very thin needle is used, common injection related reactions could occur. These could include some initial swelling, pain, itching, discoloration, bruising or tenderness at the injection site. You could experience increased bruising or bleeding at the injection site if you are using substances that reduce blood clotting such as aspirin or non-steroidal anti-inflammatory drugs as Advil.
2. These reactions generally lessen or disappear within a few days, but may last for a week or longer.
3. As with injections, this procedure carries the risk of infection. The syringe is sterile and standard precautions associated with injectable materials have been taken.

4. Some visible lumps may occur temporarily following the injection.
5. Some patients may experience additional swelling or tenderness at the injection site and on rare occasions, pustules may form. These reactions might last for as long as two weeks and in appropriate cases, may need to be treated with oral corticosteroids or other therapies.
6. Dermal fillers should not be used in patients who have experienced hypersensitivity, those with severe allergies to latex or xylocaine products (including but not limited to: xylocaine, nonacaine, zylocaine, benzocaine, prilocaine, or tetracaine) and should not be used in areas with active inflammation or infections (e.g., cysts, pimples, rashes or hives).
7. If you are considering laser treatment, chemical peels or any other procedure based on skin response after dermal fillers, or if you recently had such treatments and the skin has not healed completely, there is a possible risk of an inflammatory reaction at the implant site.
8. Most patients are pleased with the results of dermal fillers. However, like any cosmetic procedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrinkles and folds will disappear completely, or that you will not require additional treatments to achieve the results you seek. While the effects of dermal fillers can last longer than other comparable treatments, the procedure is still involving additional injections for the effect to continue.
9. After treatment, you should minimize exposure of the treated area to excessive sun or UV lamp exposure and extreme cold weather until any initial swelling or redness has gone away.

D. ALTERNATIVES

This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments include, but are not limited to Botox, Laser Skin Modalities and Cosmetic Surgery.

E. CONSENT

Your consent and authorization for this procedure is strictly voluntary. By signing this consent form, you hereby grant authority to your physician's office/authorized medical spa facility to preform Facial Augmentation and/or Filler Therapy injections using the Dermal Filler of your choice for any related treatment as may be deemed necessary or advisable in the treatment areas you choose.

The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications, have been fully explained to my satisfaction. No guarantee has been given by anyone as to the results that may be obtained by this treatment.

I have read this informed consent form and certify that I understand its contents in full. I have had enough time to consider this information from my physician's office/authorized medical spa facility, and I feel that I am sufficiently advised to consent to this procedure. I hereby give my consent to this procedure and have been asked to sign this form after being fully informed of the risks and benefits involved.

PRINT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

INJECTOR: _____ DATE: _____

I authorize and direct _____ to perform the following procedure of Botox® Cosmetic and Dysport™ injections on _____ (patient name) for the treatment of (areas to be treated:

☐☐Glabella	Initials: _____
☐☐Forehead	Initials: _____
☐☐Crows Feet	Initials: _____
☐☐Other:	Initials: _____

Please initial the following:

_____ The details of the procedure have been explained to me in terms I understand.

_____ Alternative methods and their benefits and disadvantages have been explained to me.

_____ I understand that the FDA has only approved the cosmetic use of Botox® Cosmetic and Dysport™ for from lines between the brows. Any other cosmetic use if considered off label.

_____ I understand and accept the most likely risks and complications of Botox® Cosmetic and Dysport™ injections.

Including but not limited to:

- Paralysis of a nearby muscle that could interfere with opening of eye(s).
- Local numbness
- Headache, nausea, or flu-like symptoms
- Swallowing, speech, or respiratory disorders
- Swelling, bruising, or redness at the injection site
- Disorientation and double vision
- Temporary asymmetrical appearance
- Abnormal or lack of facial expression
- Inability to smile when injected in the lower face
- Facial pain
- Product ineffectiveness

_____ I understand and accept that the long-term effects of repeated use of Botox® Cosmetic and Dysport™ injections are unknown. Possible risks and complications that have been identified but are not limited to:

- Muscle Atrophy
- Nerve irritably
- Production of antibodies with unknown effect to general health

_____ I understand and accept the less common complications, including remote risk of death or serious disability that exists with this procedure.

_____ I am aware that smoking during the pre and post-operative period could increase chances of complications.

_____ I have informed the doctor or nurse of all my known allergies, including allergies to latex.

_____ I have informed the doctor or nurse of all medications I am currently taking including prescriptions, OTC remedies, herbal therapies, and any other.

_____ I have been advised whether I should take any or all of the medications on the days surrounding the procedure.

_____ I am aware and accept that no guarantees regarding the result of the procedure have been made or implied.

_____ I understand that I will receive my treatment in a training environment and the medical professional performing this treatment is being supervising by an experienced injector. (not necessary to initial for private appointments)

_____ I understand that the medical professional supervising my injector will recommend the amount of product that he/she believes is appropriate for the results that I desire. If I chose not to accept that recommendation, I understand that I may not achieve the desired result and any further treatments to achieve the desired result will require full payment.

_____ Prices are subject to change. The pricing I receive during this treatment is only for today's treatment. Any additional treatment, products or services will be billed at rates in effect at time of the additional treatments.

_____ I have been informed of what to expect post-treatment, including but not limited to procedures I can do if I wish to maintain the appearance that this procedure provides me.

_____ I am not currently pregnant or nursing, and I understand that should I become pregnant while using Botox®Cosmetic or Dysport™ there are risks including fetal malfunction.

_____ If pre and post-treatment photos and/or video are taken of the treatment for record purposes, I understand that these photos will be the property of the attending doctor or nurse.

_____ The doctor and/or nurse has answered all of my questions regarding this procedure.

_____ I have been advised to seek immediate medical attentions if swallowing, speech, or respiratory disorders arise.

_____ I certify that I have read and understand this agreement and that all spaces for initials were filled in PRIOR to my signature.

Patient Signature: _____ Date: _____

_____ I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives of the proposed procedure to the patient. I have answered fully, and I believe that the patient fully understands what I have explained.

Doctor Signature: _____ Date: _____