Welcome to Elizabeth Patino DMD, PA's dental practice.

Consent - Treatment with botox®

I _____, have requested that Dr. Elizabeth Patino attempt to improve my facial expression lines with Botox®, which is a trademark for the *botulinum* toxin. I have disclosed my complete medical history.

These injections have been used for more than a decade in children and adults to improve the problem of muscle spasms of the facial muscles. This toxin has also been useful to correct double vision due to muscle imbalance. Cosmetically, the solution is injected with a small needle into muscle to weaken it and prevent frowning, crow's feet and/or expression lines.

Side effect and complications are usually minimal. They include but are not limited to:

1) Swelling,
2) Bruising that may last several days after the injection(s), and
3) Weakening of adjacent muscles for several weeks.

Results usually show over the next five to seven days and vary with each person. There is no guarantee concerning expected results in my case. I understand that several sessions may be needed to complete the injection series.

I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and the alternative treatments, including no treatment at all. I have had the opportunity to ask questions, read, and fully understand this form and hereby consent to treatment. I agree to hold Dr. Elizabeth Patino harmless for not meeting my expectations since I want to receive the treatment despite the possible risks

1st Patient Sig: _____ #Units:___ Date:_____ Witness:_____ Date:_____

2nd Patient Sig: _____ #Units:___ Date:_____ Witness:_____ Date:_____

3rd Patient Sig: _____ #Units:___ Date:_____ Witness:_____ Date:_____

4th Patient Sig: _____ #Units:___ Date:_____ Witness:_____ Date:_____

5th Patient Sig: _____ #Units:___ Date:_____ Witness:_____ Date:_____

6th Patient Sig: _____ #Units:___ Date:_____ Witness:_____ Date:_____

7th Patient Sig: _____ #Units:___ Date:_____ Witness:_____ Date:_____

8th Patient Sig: _____ #Units:___ Date:_____ Witness:_____ Date:_____

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Patient Information

Name: _____
SS#: _____ Date of Birth:__/__/_____
Address: _____
City: _____ State: _____ Zip: _____
Status: ☐Minor ☐Divorced ☐Single ☐Widowed ☐Married ☐Separated

Home Phone: (___) _____
Work Phone: (___) _____
Cell Phone: (___) _____
Preferred Contact: ☐Home ☐Work ☐Cell

Medical History - Treatment with botox®

Primary Physician _____ Office Phone Number (___) _____ Date of Last Exam __/__/____

Are you under any medical treatment now?	☐ No	☐ Yes: _____
Have you ever had a serious illness or operation?	☐ No	☐ Yes: _____
Have you been hospitalized within the last 5 yrs?	☐ No	☐ Yes: _____
Are you taking non-prescription medication(s)?	☐ No	☐ Yes: _____
Are you taking any medication(s)?	☐ No	☐ Yes: _____
Are you exposed to blood (occupation)?	☐ No	☐ Yes
Have you ever taken Fen-Phen/Redux?	☐ No	☐ Yes
Do you have a persistent cough?	☐ No	☐ Yes
Are you wearing contact lenses?	☐ No	☐ Yes

Women only:

Are you pregnant or think you might be?	☐ No	☐ Yes
Are you taking oral contraceptives?	☐ No	☐ Yes
Are you nursing?	☐ No	☐ Yes

Are you allergic to the following?

Local Anesthetics	☐ No	☐ Yes
Antibiotics	☐ No	☐ Yes
Sulfa Drugs	☐ No	☐ Yes
Barbiturates	☐ No	☐ Yes
Sedatives	☐ No	☐ Yes
Iodine	☐ No	☐ Yes
Aspirin	☐ No	☐ Yes
Metals	☐ No	☐ Yes
Latex Rubber	☐ No	☐ Yes

Others: _____

Do you have or have you had any of the following?

	No	Yes		No	Yes		No	Yes
High Blood Pressure	☐	☐	Respiratory Problems	☐	☐	Cancer	☐	☐
Heart Disease	☐	☐	Tuberculosis	☐	☐	Radiation Therapy	☐	☐
Heart Attack	☐	☐	Emphysema	☐	☐	Anemia	☐	☐
Stroke	☐	☐	Asthma	☐	☐	Low Blood Pressure	☐	☐
Angina/Chest Pain	☐	☐	Fainting/ Seizures	☐	☐	Recent Weight Loss	☐	☐
Heart Murmur	☐	☐	Frequently Tired	☐	☐	Kidney Disease	☐	☐
Valve Prolapse	☐	☐	Thyroid Problems	☐	☐	Liver Disease	☐	☐
Cardiac Pacemaker	☐	☐	Rheumatic Fever	☐	☐	Hay Fever/ Allergies	☐	☐
Swollen Ankles	☐	☐	Joint Replacement	☐	☐	Stomach Problems	☐	☐
Easily Winded	☐	☐	Arthritis	☐	☐	Hepatitis/ Jaundice	☐	☐
Diabetes	☐	☐	Glaucoma	☐	☐	AIDS/ HIV	☐	☐

Have you had any health problems that are not listed? ☐ No ☐ Yes: _____

Authorization and Release

I certify that the above information is complete and accurate. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ __/__/_____
Signature of Patient (or Parent/Guardian if minor) Date

Welcome to Elizabeth Patino DMD, PA's dental practice.

Patient Name _____ Date _____

I understand that the services or procedures rendered by Dr. Elizabeth Patino are completely cosmetic in nature and are not covered by insurance. No claims will be filed for any cosmetic procedures.

Full payment is due on the day that services are rendered. For your convenience, we accept cash, check, and credit cards. There is a $35 fee on any returned checks.

A $100 non-refundable deposit is required to secure an appointment. This deposit will be applied to your cosmetic procedure fees, the remaining balance is due on the same day of your procedure.

In the event of a cancellation without proper 48 hour notice, a cancellation fee of $70 will be assessed in addition to the non-refundable deposit.

I have received and understand these policies and agree to the terms listed above.

_____ _____

Patient Signature Date

7109 NW 11th Place, Ste F. Gainesville, Florida 32605 - Phone: 352.331.8683 Web: epDentistry.com

Thank you for choosing us as your dental healthcare provider.

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Disclosures to Friends and/or Family Members (HIPPA)

I**, (Print your name) _____** give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below: (Please list any family members as well as any others in the space below)

Family members:

_____

Consent for Photographing or Other Recording for Security and /or Health Care Operations

***_____ (Patient Initials)** I consent to photographs, videotapes or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvements activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the practice without a specific written authorization from me or my legal representative in less otherwise required by law.

Consent to Receive Text Messages or Emails about Appointments Reminders:

Patients in our practice may be contacted via email or text messaging to remind you of an appointment.

***_____ (Patient Initials)** I Consent to received text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive appointments reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.

The **cell** phone number that I authorized to received text messages for appointment reminders is (_____)_____.

The **email** that I authorized to receive text messages for appointments reminders is _____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carries for pricing plan and details).

Signature: _____ Date: __/__/_____

Patient Name (print):_____ Date: __/__/_____

Revocation (if you do NOT want us to email or text you).

I hereby revoke me request for future communications via email and/or text.

____ I hereby revoke my request to receive any future appointments reminders via text messages.

____ I hereby revoke my request to receive any future appointment reminders via email.

NOTE: This revocation only applies to communication from this practice.