COASTAL DENTISTRY

INJECTION INFORMED CONSENT

Please read and initial appropriate sections as designated

Name _____ Date _____

_____ This consent form is designed to verify that you have been satisfactorily informed and educated in respect to your injection treatment as well as any aftercare and possible side effects, so that you can make an educated decision as whether to have this procedure performed.

_____ I understand that Botox Cosmetic® is the trademark for the bacteria clostridium botulinum and is injected into specific muscles to cause temporary paralysis in an effort to reduce the appearance of frown lines, crow's feet, and other facial expression lines.

_____ I understand that Juvêderm® is from culturally derived purified sources, which are approved to be injected directly into specific wrinkle lines/furrows and/or skin depressions in an effort to reduce the appearance of frown lines, crow's feet, and other facial expression lines related to aging, sun damage, and/or muscle overuse.

_____ Although the results of these types of aesthetic dermatologic injections are usually dramatic and positive, I have been informed that it is not an exact science and that no guarantees can be made regarding expected results in any case. After multiple injections, it is also possible that your body may produce antibodies reducing the effectiveness of the treatment(s).

_____ I certify that I am not pregnant (if female) and that I have no significant neurological disease, asthma, HIV, and/or facial herpes. Also, to the best of my knowledge, I certify that I have no allergies or sensitivities and that I am not allergic to eggs/egg products or lidocaine.

_____ I understand that improvement in the areas injected typically occurs within ten days. If satisfactory results are not achieved within that timeframe, I understand that I can call to set up an appointment for re-injection/touch-up. Unless special arrangements have been made, there are charges for re-injection to cover the cost of materials. I understand that beyond (21) days after initial treatment I will be charged normal injection fees. Also, I understand that only one re-injection session is allowed per treatment.

_____ Injections of therapeutic solutions are made through extremely fine needles into the skin and superficial muscles. I understand that benefits are sometimes evident immediately after treatment, but typically develop within three to ten days afterward.

_____ I understand that side effects/complications are infrequent, but occasionally headache, slight swelling and/or bruising may occur after treatment(s) for a few minutes to several days after injection(s). Rarely, a muscle close to an injection site may be temporarily weakened for several weeks as a result solution migration in the injected tissue. I have been advised of the risks involved with therapeutic injections and of the alternative treatments including no treatment at all.

_____ I am aware that several treatments may be needed to attain the most desired results and that follow-up injections are inevitably necessary to maintain desirable results. The timeframe varies for each patient, but generally speaking, each completed treatment lasts for approximately three months.

_____ I understand that post-treatment instructions include avoidance of manipulation/vigorous rubbing of the treated areas as well as avoidance of vigorous physical activity for four hours post- treatment.

_____ I agree that this form constitutes full disclosure and that it supercedes any related previous communication(s). All of my questions have been satisfactorily answered and I am prepared to undergo the designated injection treatment(s).

Patient Signature_____ Date _____

Dentist's Signature_____

Date _____