Please Write Legibly
Print Only

Dale B. Smith, D.O.
Board Certified Facial Plastic Surgeon

Name: ____ **Birth Date** : ________________ **Age**: ____ **Gender: Male__ Female__**

Home Phone: ___________________________ **Work:** __________________________ **Cell:** _______________________________________

Address: ____ **City:** _______________________ **State:** _______ **Zip:** __________________

Emergency Contact: ____ **Phone:** ________________________________

Email: _______________________________________ **Join our email list:** ❑yes ❑no **Occupation:** _______________________________

Y N Are you currently under the care of a physician? If yes, for what: _____________________________
Y N Are you currently under the care of a dermatologist? If yes, for what: ____________________________
Y N Do you suffer from any chronic skin conditions? (example: Acne) If yes, what type: _____________________________
Y N Do you wear sunscreen daily?
Y N Are you currently under a lot of stress?
Y N Do you smoke?
Y N Are you currently pregnant or breastfeeding?
Y N Have you ever used Accutane? (prescription medication to treat certain skin diseases/acne)
Y N Do you use a tanning bed?
Y N Are you currently using Retin-A, Retinol, Glycolic Acid or any other skin exfoliating products or prescriptions?
Y N Do you have implants/stents in the facial area? (metal stents, implanted electrical devices, mechanical or other implants)
How much sleep do you get per night? _______________ (hours)

Are you or have you experienced any of the following health conditions:

___ Diabetes	___ Glaucoma	___ Sinus Problems	___ Keloid Scarring	___ Tuberculosis	___ HIV/AIDS	___ Bell's Palsy
___ Contact Lenses	___ Sensitive Eyes	___ Shingles	___ Hepatitis	___ Laser Resurfacing	___ Mental Disease	___ Autoimmune Disease
___ Sensitivity to Soap	___ Skin Lesion	___ Fever Blisters/Herpes	___ Bleeding disorder	___ Chemical/Acid Peel	___ Cosmetic Surgery	___ Migraines
___ Hormone Imbalance	___ High Blood Pressure	___ Thyroid Imbalance	___ Epilepsy	___ Anxiety Attack	___ Cancer	___ Other

What is your skin type? ___Normal ___Oily ___Combination ___Dry

Have you ever had a reaction or sensitivity to a skincare product or treatment? If yes, please explain.

____

____

Please list all skincare products you currently use.

____

____

Please list any facial treatments you have had in the past.

____

____

Please list ALL medications you are currently taking (vitamins, OTC, aspirin, birth control, etc.)

____

____

Please list ALL known allergies (food, drug, animal, product, latex, etc.)

____

Please list ALL surgeries you have had and date of surgery (removal of teeth, child birth, etc.)

____

____

How did you hear about us? (circle one)
Friend/Family (name of referring person/s):__________________________ Newspaper TV commercial Website Phonebook Facebook Billboard Magazine

Salon(name of salon): ______________________________ Other (please describe): ___________________________

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that is it my responsibility to inform the Esthetician, Doctor, Nurse, or other Staff of my current medical or health conditions and when such conditions change.

Signature: (**must be signed**) ____ Date: _________________________

Esthetician: ____ Date: _________________________

OFFICE USE ONLY
❑Demographics ❑CC ❑Review Hub

4920 SW Lee Blvd.
Lawton, OK 73505
(580) 536-5192

SKIN SECRETS
FACIAL PLASTIC SURGERY & MEDICAL SPA

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Consent to Botulinum Toxin "A" Treatment

Patient Name: ______________________________ **Date:** ____________

Circle any of the following illnesses you have or have had in the past:

Myesthenia Gravis   Hepatitis   Eye Disease   Autoimmune Disease   Vision Problems

Numbness   Muscle Weakness   ALS   Eaton Lambert Disorder

Explain: ____

Previous Hospitalizations: ____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Botox® is a neurotoxin produced by the bacterium Clostridium A. Botox® can relax the muscles on areas of the face and neck which cause wrinkles associated with facial expressions. Treatment with Botox® can cause your facial lines or wrinkles to essentially disappear. Areas most frequently treated are glabellar area of frown lines located between the eyes, crow's feet, and forehead wrinkles. Botox® is diluted to a very controlled solution and when injected into the muscles with a needle, it is almost painless. Clients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results last 3-6 months. With repeated treatments, the results may tend to last longer.

Risks and Complications
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, bruising 2. post treatment bacterial, fungal, and/or viral infection requiring further treatment 3. allergic reaction 4. minor temporary droop of eyelid(s) which usually lasts 2-3 weeks 5. occasional numbness of the forehead lasting up to 2-3 weeks 6. transient headache 7. flu-like symptoms may occur.

Pregnancy, Allergies, and Neurologic Disease
I am not breast feeding. I am not aware that I am pregnant, have any significant neurologic disease, or have any allergies to the toxin ingredients, or to human albumin.

Payment
I understand that this procedure is cosmetic and that payment is my responsibility.

Results
I am aware that when small amounts of purified botulinum (Botox®) are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 3-7 days and usually lasts 3-6 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. I understand that I will not be able to "frown" 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 of the injection for the four hours post-injection period.

I hereby voluntarily consent to the treatment with Botox® injection for the condition known as: Facial Dynamic Wrinkles. The procedure has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure.

Patient Signature: ______________________________ **Date:** ____________

Witness Signature: ______________________________ **Date:** ____________

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BOTOX® Post-Treatment Instructions

1. Do not lie down or elevate your head back for 3-4 hours after your BOTOX® treatment.

2. Avoid strenuous exercise for 24 hours after treatment.

3. Avoid facials and saunas for 4 hours after treatment.

4. Continue facial movements as normal. There is no need to exercise the facial muscles or to avoid facial movements.

5. Avoid manipulation of the area the first hour after the procedure.

6. If you need to apply make-up, use only a gentle touch in an upward motion, and avoid rubbing injection sites.

7. Tiny bumps and marks at the injection sites usually disappear within a few hours.

8. Going for a walk or run after injections is okay.

Important Reminders:

• It usually takes 3-8 days for full treatment effects to appear.

• Results last 3-6 months on average.

• Regular treatment is necessary to maintain results, optimally done just prior to BOTOX® wearing off.

• An enhancement may be necessary in 1-2 weeks. If feel that you need an enhancement, you are responsible for the injection fee of $12/unit.

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Authorization For and Release of Medical Photographs

In order to track your progress, we at Skin Secrets like to incorporate the use of photos &/or videos. **Photos are used for documentation purposes**, and if consented as advertisement for the product/service. We would appreciate your willingness to share your results with others for training and marketing purposes.

If you consent, you authorize Skin Secrets, Dr. Smith and their associates or licenses to use pre-procedure, during and post-procedure photographs &/or videos for professional medical purposes as deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, Skin Secrets website, for purposes of medical education, patient education, or during lectures to medical groups.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your physician/esthetician.

Please initial the following:

___I understand that pre-procedure, during and post-procedure photographs will be used for documentation purposes in my chart.

In addition:

These photographs &/or videos **MAY**______ or **MAY NOT**_______ be used for advertising purposes.
Please: _____Block out eyes
_____Zoom in on treated areas only
List any other restrictions you have_________________________________

___I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Print Name: ____ DOB:_____________

Patient Signature: _______________________________________ Date:_____________

Witness: ____ Date:_____________

SKIN SECRETS
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Scheduling Policy

Deposits: All deposits are non-refundable. A $50 deposit is required for all new patients to schedule Botox or filler appointments. A $75 deposit is required for all patients to schedule a consultation with Dr. Smith. All deposits will be used towards your treatment that is scheduled within 90 days. If you do not show for your appointment, your deposit is no longer eligible to be used towards any treatments/products. You will be required to pay an additional deposit prior to scheduling any appointments. A $500 deposit is required to schedule any surgeries/procedures (excluding injections) with Dr. Smith. Then, the remaining balance is due at least one week prior to your surgery.

No-shows: If you do not show for your appointment, you will be charged half the price of the treatment(s) you were scheduled for. This will have to be paid prior to scheduling any other appointments and will not go towards your next treatment. If you have purchased a treatment package and do not show for one of your sessions, the missed session will be forfeited.

Late Arrival: If you arrive late to your appointment, you may be required to reschedule to another day. If you are running late, please call to see if you are still able to receive your full service.

Your time as well as ours is very valuable to us. A 24-hour cancellation/reschedule notice is appreciated if you find you are unable to keep your appointment.

By signing below, I certify that I have read and understand the contents of this policy.

_________________________________ ____________ ____________
Patient Name Printed Date of Birth Date

____
Patient Signature