Jacqueline Braunworth, PA-C

Christie Sullivan, M.D.

Patient Information and Medical History

Name:_____Date of Birth_____Today's Date_____

Address:_____City_____State_____Zip_____

Home phone_____ Cell Phone_____ Phone preferred: □ home □ cell

□ Male □ Female Email address: _____

What brings you in today?_____

History

Please check if you have or have had

□Diabetes □Irregular Menses □Hepatitis □Heart Problems □Herpes
□Hysterectomy □Menopause □Sensitivity to anesthetic □Photosensitive disorder □Lupus
□Autoimmune Illness □Seizures

Are you under the care of a physician for any reason? □ yes □no
If yes, why:_____
Please list your current Mediations (including Herbals and over the counter):

_____

_____

Please complete the following:

	Yes	No	If yes, explain
Keloid Scars			
Hives			
Skin Cancer			
Waxing			
Electrolysis			
Cold sores			
Hypersensitivity to skin products			
Skin infections			
Tanning within last 6 weeks			
Use of acne products/drugs			
Laser skin resurfacing			
Chemical peels/facials			
Photo sensitizing substances			
Laser work of any type			

Please list any medical illnesses:_____
Are you pregnant? □yes □ no Are you breastfeeding? □ yes □ no
Allergies of any kind (including drug allergies):_____

I attest that the above information is true to the best of my knowledge. I understand that my provider relies on this information to provide safe and effective treatment.
Patient Signature_____Date_____

Jacqueline Braunworth, PA-C

Christie Sullivan, M.D.

Botox®/Dysport® Consent Form

I understand that I have agreed to treatment with the Use of Botox® and/or Dysport® for the temporary treatment of superficial facial wrinkle.

I authorize Jacqueline Braunworth, PA-C to perform this treatment.

The nature and purpose f the treatment has been explained to me and all my questions regarding the treatment have been answered to my satisfaction.

I understand that surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles.

I am fully aware of the risks of complications or injuries that can occur from this treatment, both from known and unknown causes and I freely assume those risks.

Known complications could include: redness, swelling, itching, pain or pressure lasting more than 1 week, nodules, or induration at the injection site, discoloration of the injection site, poor effect, allergic reactions, effects of Botox® are apparent 2-7 days after treatment and can last anywhere from 2-6 months, periodic treatment will be necessary to maintain the effects of Botox®, repeated treatment may lead to permanent loss of muscle tone in the treated area, bruising, facial asymmetry, paralysis leading to droopy eyelid and double vision, some patients may experience weakness or flu-like symptoms, visual problems, dry eyes, some patients may develop antibodies to Botox®. Effects of Dysport® are apparent 2-5 days after treatment and can last anywhere from 2-6 months.

I certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of autoimmune disease, or immune therapy. I am not pregnant, breast feeding and I have no known allergy to Botox®/Dysport®

I certify that I have read this entire informed consent and that I understand and agree to the information stated in the form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained.

There is no guarantee, warranty or assurance made as to the treatment results.

I will hold Jacqueline Braunworth, PA-C and Christie Sullivan, M.D. harmless from all and any litigation or claims made should I have any adverse reaction to Botox®/Dysport® or reaction to Botox®/Dysport®. Further, I hold them completely harmless from malpractice suits or claims made in relation to my receiving Botox®/Dysport®.

I am not planning a Lasik® procedure within the next 6 months.

I understand that the results are temporary in nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here:No laying down or reclining for 4 hours after injection, no scratching or rubbing the injected area, no bending forward for 4 hours, make up should be avoided for 1-2 hours after injection.

This agreement is non-transferable and may not be altered by anyone without the express written consent of Jacqueline Braunworth, PA-C or Christie Sullivan, M.ED. Further, this agreement does not expire.

I agree to pay in total for the above mentioned services.

Patient Name (print):_____

Signature:_____ Date:_____

Witness:_____ Date:_____

Jacqueline Braunworth, PA-C

Christie Sullivan, M.D.

Injectable Filler Consent Form

I understand that I have agreed to treatment with the Use of Injectable Filler to improve the appearance of scars and/or wrinkles, or to have my lips augmented (made larger), my cheeks augmented. The fillers to be used include Hylaform, Restylane, Collagen, Juvederm (Plus/Ultra Plus/Voluma), Radiesse.

I authorize Jacqueline Braunworth, PA-C to perform this treatment.

The nature and purpose of the treatment has been explained to me and all my questions regarding the treatment have been answered to my satisfaction.

I understand that surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles.

I am fully aware of the risks of complications or injuries that can occur from this treatment, both from known and unknown causes and I freely assume those risks.

Known complications could include: redness, swelling, itching, pain or pressure lasting more than 1 week, nodules, or induration at the injection site, discoloration of the injection site, poor effect, allergic reactions, periodic treatment will be necessary to maintain the effects, poor effect or weak filling, bruising, facial asymmetry, in extremely rare cases, skin necrosis or death of skin, may occur as a result of injection into a blood vessel. This may result in financial costs, extended care and scar formation.

I certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of autoimmune disease, vascular disease, HIV disease, psychiatric disease or immune therapy. I am not pregnant, breast feeding and I have no known allergy to Hylauronic acid, anesthetic agents, latex gloves (should they be used) or bovine sourced collagen.

I certify that I have read this entire informed consent and that I understand and agree to the information stated in the form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained.

There is no guarantee, warranty or assurance made as to the treatment results.

I will hold Jacqueline Braunworth, PA-C and Christie Sullivan, M.D. harmless from all and any litigation or claims made should I have any adverse reaction to any of the above-mentioned fillers or reaction to any of the above-mentioned fillers. Further, I hold them completely harmless from malpractice suits or claims made in relation to my receiving any of the above-mentioned fillers.

I understand that the results are temporary in nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here: avoiding prolonged sun or UV exposure, avoiding saunas for 2 weeks after injection, avoiding steam baths for 2 weeks after injection, make up should be avoided for at least 12 hours after injection.

This agreement is non-transferable and may not be altered by anyone without the express written consent of Jacqueline Braunworth, PA-C or Christie Sullivan, M.ED. Further, this agreement does not expire.

I agree to pay in total for the above mentioned services.

Patient Name (print):_____

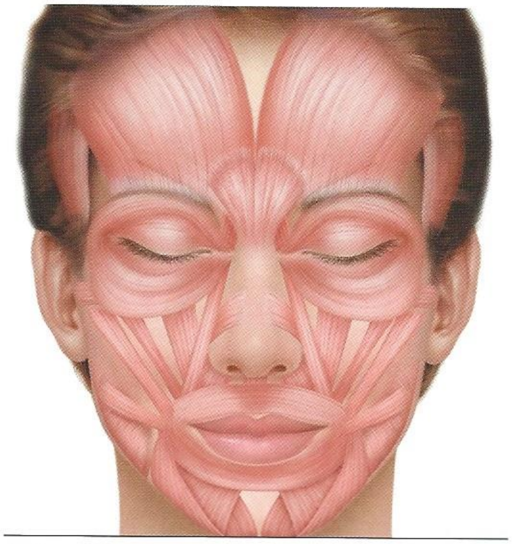
Signature:_____ Date:_____

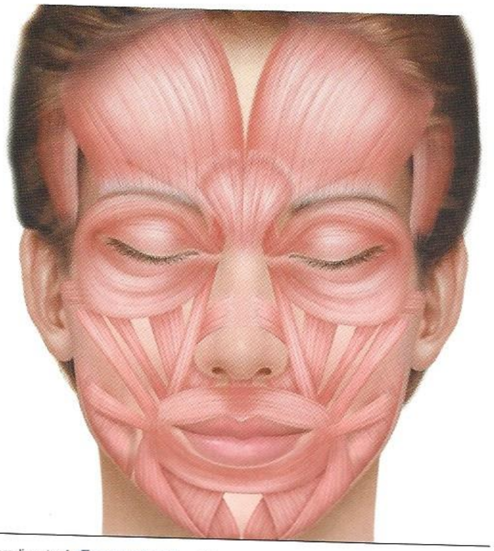
Witness:_____ Date:_____

Jacqueline Braunworth, PA-C
Christie Sullivan, M.D.
203-215-9734

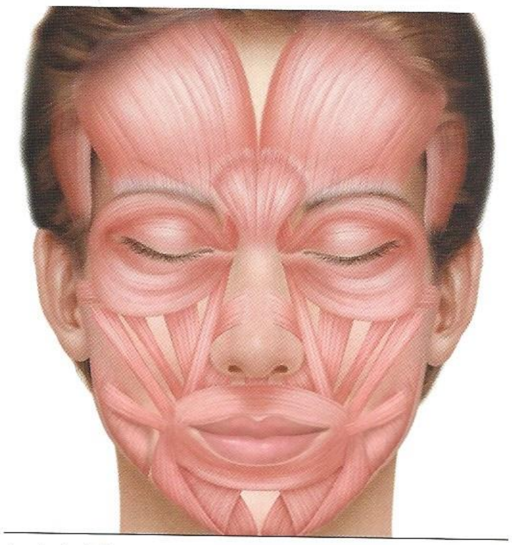
Botox Treatment Log

Date	Product	Glabella	Forehead	Crows Feet	Bunny Lines (nose)	Spa Lift (lateral brow)





Compliments of ALLERGAN ©2006 Allergan, Inc., Irvine, CA 92612 Re-order: 4960568



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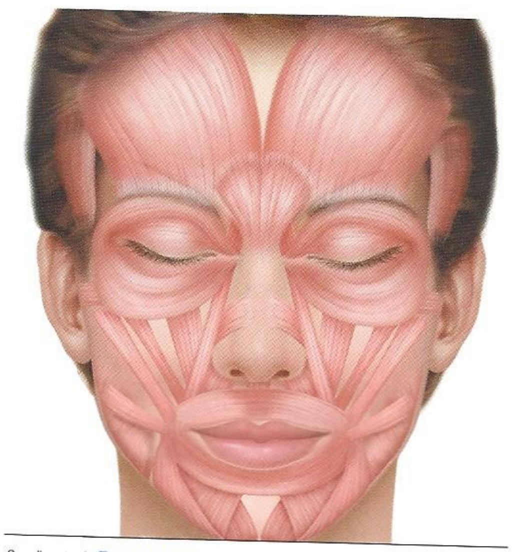

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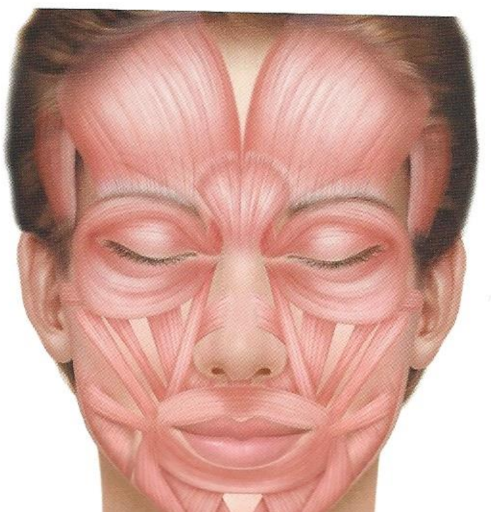

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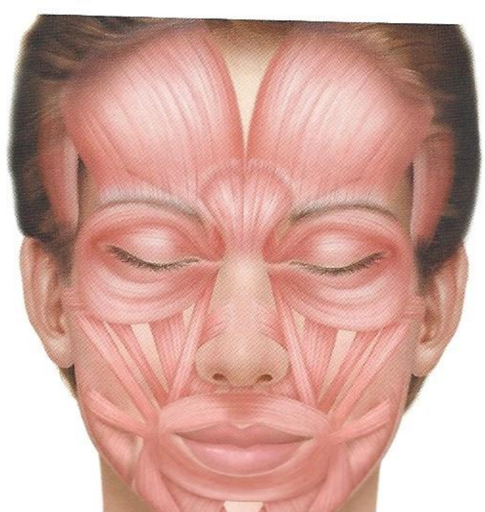

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Filler Treatment Log

Date	Product	Product ID sticker	Lips	Nasolabial folds	Cheeks	Eyes