Paragon Plastic Surgery & Med Spa

Botox / Fillers / Injectables / Skin Care History

Full Name _____ Date _____

Address _____City _____State _____ Zip_____

*Email address _____SSN#_____

Home phone _____Cell_____Work_____

May we contact you at home, on your cell or at work?_____

Emergency Contact: _____Relation:_____Number: _____

Date of Birth: _____ Age: _____ Gender:_____

Marital Status _____ Number of children_____

Occupation/Employer_____ Ht_____ Wt_____ (lbs)

Race: Caucasian African American Hispanic Asian Other

How did you hear about our office? _____

Reason for visit, why are you here today?_____

_____

___**Sun damage**	___**Brown spots/uneven skin**	___**Dry patches**
___**Clogged pores**	___**Acne/pimples**	___**Unwanted Hair**
___**Scarring**	___**Wrinkles**	___**Dermatitis**
___**Excessive oiliness**	___**Blackheads/whiteheads**	____**Rosacea**
___**Upper lip lines**	___**Freckles**	

What conditions/problem areas would you like improved:

How much time do you spend in the sun?_____Do you use Tanning beds? Yes No

Do you wear sunscreen?_____How often?_____SPF/Brand_____

How would you describe your skin? _____

In the sun, do you? Always burn, Sometimes burn, Sometimes tan, Never burn, Always tan

Allergy to medication:_____

Bad reaction to cosmetics: _____Allergy to latex/Other:_____

Are you pregnant? _____ Are you breast feeding?_____

Amount of water you drink a day :_____ 8oz glasses.

Please list any medical conditions:

_____

_____

_____

1101 Matlock Rd. Mansfield Texas 76063
ph 817-473-2120 fax 817-887-5233

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AIDS
Anemia
Arthritis
Asthma
Blood disease
Blood transfusion
Cardiac problems
Chemotherapy
Chronic headaches
Dermatitis
Diabetes
Dizziness
Epilepsy
Eczema
Fainting
Fibromyalgia
Hay fever
Heart disease
Hepatitis
High blood pressure
Infection (active)
Immune disorders
Keloid scars
Kidney disease
Liver disease
Lupus
Melanoma
Nervous disorder
Pacemaker
Psoriasis
Radiation treatment
Respiratory disorder
Rosacea
Skin cancer
Skin disease
Sinus problems
Stomach problems
Stroke
Thyroid problems
Tuberculosis (TB)
Urinary problems
Ulcers
Venereal disease

****Cold Sore / Fever Blister**

Frequency < 1/year

Frequency 1-3/year

Frequency >4-1-/year

Have you ever had the following conditions:
List all medications you are presently taking:

_____

_____

_____

bHcg (beta hCG)
Birth Control
Testosterone
Minoxidil
Aldactone
Retin-A Renova
Accutane
NSAIDS / Aspirin
Tetracycline
DHEA
Blood Thinners
Steroids
Thyroid
Chemotherapy
Antidepressants
Vitamin E
Herbals
Acne Medication

___Acid Peels Date:_____

____Botox Date: _____

____Fillers / Injectables Date: _____

___Tattoo/Perm Makeup Date: _____

___Waxing Date: _____

___Facial Plastic Surgery Date: _____

___Laser Surgery Date: _____

____Microdermabrasion Date: ____

Check all medications that apply:

Previous Cosmetic Facial Treatments, Surgery, Resurfacing, or Laser Treatments:

I have answered the above questions truthfully and will notify you of any changes in medications and physical conditions.

Patient Signature:_____ **Date:** _____

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Botox® / Filler Pre-Treatment Medical History

Results from Botox® Cosmetic and/or Fillers should be realistic. The goal of Botox is to soften wrinkles and to provide a relaxed look. Botox® Cosmetic is FDA approved for the temporary improvement in the appearance of glabellar lines between the eye brows. Fillers including Restylane, Perlane, Juvederm Ultra, Juvederm Ultra Plus and Juvederm Ultra Plus XC are designed to restore volume and fullness to the skin, and to correct moderate to server facial wrinkles and folds. Possible side effects include the following but are not limited to: Injection site discomfort, headache, respiratory infection, flu-like symptoms, blepharoptosis (drooping of upper eyelid), bruising, swelling, tenderness, pain, itching, rash, change in skin color, scab formation, skin exfoliation, skin necrosis, blindness, and nausea. All likely side effects are temporary and uncommon.

Please list all allergies to medicine:_____

Any history of anaphylactic or allergic reaction(s)?_____ If yes, please explain:

_____

Any allergic reaction to botulinum toxin?	___Yes ___NO
Any history of swallowing problems?	___Yes ___NO
Any history of asthma or emphysema?	___Yes ___NO
Any history of a slow heart rate or rhythm?	___Yes ___NO
Any history of neuromuscular disease?	___Yes ___NO
Are you allergic to albumin (eggs)?	___Yes ___NO
Are you allergic to cows milk?	___Yes ___NO
Are you allergic to lidocaine?	___Yes ___NO
Are you pregnant or nursing?	___Yes ___NO
Are you allergic to gram positive bacteria proteins:	___Yes ___NO
Do you have a bleeding disorder?	___Yes ___NO
Are you taking Vitamin E or other supplements?	___Yes ___NO
Are you taking aspirin or ibuprofen?	___Yes ___NO
Are you taking Coumadin or Plavix?	___Yes ___NO
Have you ever had a cold sore / fever blister?	___Yes ___NO
Do you have a current infection?	___Yes ___NO
Laser Surgery in the past 14 days?	___Yes ___NO
Chemical Peel in the past 14 days?	___Yes ___NO
Do you have an active infection?	___Yes ___NO

Patient Signature: _____ Date: _____

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Full Name _____Date _____

Botox / Injectables / Fillers Consent

Belatero, Juvederm, Juvederm Ultra, Juvederm Ultra XC, Juvederm Ultra-Plus XC, Voluma XC, Radiesse, Botox and Xeomin.

Purpose and Background

You have requested the administration of an injectable dermal filler, (non-animal stabilized hyaluronic acid or calcium hydroxyapetate (NASHA)) and/or Botox Cosmetic to be 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 or not to go forward with the procedure.

Procedure

The product is administered by injection of the dermal filler and/or botox cosmetic into specific areas of your face with the filler to reduce the appearance of wrinkles and folds. A field block with lidocaine may be requested to reduce the discomfort of the dermal filler injections. If the treated area is swollen directly after the injection, ice packs may be applied for a short period of time.

Risks/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 other non-steroidal anti-inflammatory drugs such as Advil®.

2. These reactions generally lessen or disappear within a few days but may last for a week or longer. 3. As with all 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 in rare occasions, pustules might form. These reactions might last for as long as approximately 2 weeks, and in appropriate cases may need to be treated with oral corticosteroids or other therapy.

6. Injectables should not be used in patients who have experienced this hypersensitivity or those with severe allergies.

7. Injectables should not be used in areas other than the tissues of the face.

8. If you are considering laser treatment, chemical skin peeling or any other procedure based on a skin response after juvederm or radiesse treatment, or you have recently had such treatments and the skin has not healed completely, there is a possible risk of an inflammatory reaction at the implant site.

9. Most patients are pleased with the results of an injectable treatment. 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 filler use can last longer than other comparable treatments, the procedure is still temporary. Additional treatments will be required periodically, generally within 6 months to one year, involving additional injections for the effect to continue.

10. 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. Injectables have been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in the skin on the face. The effect, once the optimal location and pattern of cosmetic use is established, can last 6 months or longer without the need for re-administration.

11. Blindness, although extremely rare, is possible and has been reported in the lititure. Please report any visual changes immediately.

Alternatives

This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments which very in sensitivity, effect and duration include: animal-derived collagen filler products, dermal fillers derived from the patient's own fat tissues, synthetic plastic permanent implants, or bacterial toxins that can paralyze muscles that cause some wrinkles.

Photography

I hereby give my permission to the medical personnel to take photographs of all treated sites for diagnostic purposes and to accurately document the medical record in the usual and customary manner. I agree that these photographs are the property of Paragon Plastic Surgery & MedSpa LLC., and my photographs can be used for teaching purposes, to illustrate scientific papers, books or for use in general lectures. It is specifically understood that in any such publication or use, I shall not be identified by name.

In regards to Botox Cosmetic Injection:

1. The diagnosis requiring this procedure is hyperactive galbellar facial muscles.
2. The nature of the procedure is to temporary paralyze the facial muscles.
3. The purpose of this procedure is to temporarily reduce muscle activity and decrease facial lines.
4. The material risks of this or any procedure may include infection, allergic reaction, disfigured scar, drooping eyelid, drooping eyebrow, double vision, bruising, swelling, headache, malaise, flu like symptoms, incomplete paralysis of muscles, no paralysis or no effect at all.

Follow UP Suggested by the Doctor

I agree to follow up with Dr. Mark A. Bishara in one week following my treatment and at reasonable intervals as needed to assess my status. I agree to inform him of any problem that I am having and to allow him to see me at that time. If second opinions or consultants are recommended I agree and plan to follow those suggestions.

I understand that Dr. Mark A. Bishara, his medical personnel, and nurses must rely upon statements by me about my medical history and other information about me in determining whether to recommend the procedure that has been explained. I also understand the practice of medicine is not an exact science and that no guarantees have been made to me concerning the results of this procedure. Mark A. Bishara also understand that during the course of the procedure described above, Dr. Mark A. Bishara may

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become aware of conditions that were not apparent at the time this consent was given. I further understand that unforeseen emergencies may arise during the course of treatment, therefore, I consent to any additional or different procedures, which Dr. Mark A. Bishara considers necessary or appropriate to treat, cure, or diagnose such conditions including admission to a hospital if necessary, and I will be responsible for any further fees incurred. I consent to the taking of photographs before and after and in the course of treatment to be used for medical instructional purposes including lectures and/or publications. Your consent and authorization for this procedure is strictly voluntary. By signing this informed consent form, you hereby grant authority to Dr. Mark A. Bishara and/or an appointed employee of Paragon Plastic Surgery to perform Facial Augmentation using dermal filler therapy, botox or injectables as may be deemed necessary or advisable in the diagnosis and treatment of your condition.

The nature and purpose of this procedure, with possible alternative methods of treatment, as well as complications, have been fully explained to your satisfaction. No guarantee has been given by anyone as to the results that may be obtained by this treatment. I confirm, to my knowledge, I am not pregnant at this time.

I have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information from Dr. Mark A. Bishara and feel that I am sufficiently advised to consent to this procedure. I hereby give my consent to this procedure.

PatientSignature:_____Date: _____

Physician Signature:_____ Date: _____

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Consent To Treatment, Release of Information, Financial Agreement

CONSENT TO TREATMENT: I understand and acknowledge that Texas Law provides that if any health care worker is exposed to my blood or other bodily fluid, this practice may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including HIV, with or without my consent. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of this surgical practice. I understand the results of tests taken under these circumstances are confidential and do not become part of my medical record. I give my consent to Dr. Mark A. Bishara or his designees to perform or administer all tests and treatment that, in the judgment of Dr. Mark A. Bishara, is advisable during my visit to this surgical practice.

RELEASE OF INFORMATION: I authorize to release/obtain information contained in my financial and medical records, including diagnosis and test results, to/from (a) any of my treating practitioners, (b) my insurance company or health care plan or its representative, or its agents or independent contractors or (c) any other person or entity that is responsible for paying or processing for payment any portion of my medical treatment bill or (d) to any person or entity for the purposes of administration, billing, collecting, and quality assessment and risk management or to any hospital, nursing home, home health agency or to any healthcare institution to which I am transferred. I understand this consent applies to all records created in the course of and relating to my care. I release and agree to hold harmless the surgical practice of Dr. Mark A. Bishara and his representatives and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand this surgical practice cannot be responsible for use or redisclosure of information by third parties.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: In consideration for the medical and surgical services to be or have been rendered to me, I agree to pay for those services. I agree to assign to Dr. Mark Bishara , the benefits under my insurance policies or prepaid health care plan or other reimbursement source. I acknowledge that any balance not covered or paid by such policy or plan is my legal and financial responsibility. I acknowledge that I am aware this practice does not charge interest for late payments. I acknowledge that I am aware that any balance not covered or paid after 120 days, will be turned over to a collection agency and this practice will initiate termination of my patient-physician relationship as described by Texas Law. I acknowledge that any billing-related complaint will be directed to the billing compliance officer. I acknowledge and I am aware that cosmetic surgery procedures are not covered by the benefits under my insurance company and Dr. Mark A. Bishara does not accept insurance reimbursements for cosmetic surgery procedures and all charges related to cosmetic surgery are my own financial responsibility. I understand that there is a $35 NSF for all returned checks. I acknowledge that I am aware the policy of billing practices and the policy of charity care are both available upon request.

THIS IS A LEGAL CONSENT, FINANCIAL AGREEMENT, AND ASSIGNMENT OF BENEFITS FORM. PLEASE READ IT CAREFULLY AND BE SURE YOUR QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING.

Signature :_____ Name:_____

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PHOTOGRAPHIC CONSENT

Date_____Full Name_____

I, hereby authorize and consent that any and all photographs, images, or videos taken by Dr. Mark A. Bishara at Bishara Cosmetic Surgery Center of any part of my body, whether originals or reproductions, may be utilized for such purposes as he may desire in connection with his research, writing, professional activities, and may be used, exhibited and published through any medium whatsoever as part of or in connection with his research, writing, and professional activities, even though such use may be for advertising purposes or purposes of trade. This consent is not retractable, either by oral or written means.

I certify that I have read and understand the aforementioned and sign my name below giving authorization and consent to the foregoing and any photographs, image, or videos taken for future surgeries.

Patient Signature:_____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

Health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice maybe changed at any time. I may obtain a revised copy of the Notice by requesting one at this office.

Do you have any restrictions as to how we contact you?_____

Special Instructions:_____

_____

Signature:

Patient Name*: _____

Date:_____

*** If signed by a personal representative, please state your authority to act for _(Name)_____**

THIS SPACE TO BE USED BY PRACTICE ONLY

Patient Acknowledged Notice of Privacy Practices on Form Provided and Returned Signed Copy.
Accepted _____Denied_____

If Refuse to Sign, Document Reason in Chart: _____

Note: Cannot refuse to see patient if patient refused to sign Acknowledgement

Signed Acknowledgement _____

Accepted or Denied _____

Name of Employee Documenting _____

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Botox® Cosmetic
AFTER CARE SHEET

1. Make facial expressions in treated areas for 4-6 hours after procedure.

2. DO NOT press on injection sites for 24 hours. If you had Botox injected into your forehead, do not year a hat or headband for 24 hours.

3. Do not exercise 4-6 hours after injections.

4. Avoid heavy lifting or bending 4-6 hours after injections.

5. Most common side effects include redness, tenderness, itching or rash at injection site.

Injectables / Dermal Fillers
Juvederm Ultra, Juvederm Ultra Plus, Juvederm Voluma, Radiesse & Beloterro

AFTER CARE SHEET

1. After your treatment, you might have some redness, burning and swelling. This will normally last less than seven days. Cold compresses may be used immediately after treatment to reduce swelling.

2. Avoid direct sun exposure and cold outdoor activities until any redness or swelling disappears.

3. If you have previously suffered from facial cold sores, there is a risk that the needle punctures could contribute to a recurrence. We will prescribe you a medication if necessary to prevent an outbreak of cold sores. Please contact our office if you have concerns.

4. Do not exercise 4-6 hours after injections.

5. Avoid heavy lifting or bending 4-6 hours after injections.

6. If you are experiencing mild pain you may take Tylenol. However, do not take aspirin or ibuprofen for 3-5 days after injections.

Though extremely rare, seek immediate medical attention if any anaphylactic phenomenon arises.
Call our office with any questions or concerns 817-473-2120.

Mark A. Bishara, M.D., P.A.
Paragon Plastic Surgery & Med Spa

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