

ENLIGHTEN
NEW PATIENT INFORMATION

NAME _____

DOB _____

ADDRESS _____

CITY, ST, ZIP _____

AGE _____

REFERRED BY _____ (whom may we thank?)

SEX: M / F

OCCUPATION _____

EMAIL _____

PHONE# _____ CELL

_____ HOME

MEDICAL HISTORY

1. Do you have any current or chronic medical illness we should know about?

Please list _____

2. Do you take any medications on a regular basis?

Please list _____

3. Do you have any allergies to medications?

Please list _____

4. Do you have herpes I or II in the areas to be treated? _____

SKIN HEALTH HISTORY

What treatments are you interested in?

- Permanent hair removal
- Skin discoloration
- Acne
- Wrinkles/fine lines
- Melasma
- Rosacea
- Leg veins
- Clogged pores
- Skin care
- Botox
- Juvederm (wrinkle filler)
- Lip enhancement
- Skin resurfacing

What treatments have you had?

- Waxing
- Electrolysis
- Laser treatments
- Acne meds/ treatments
- Chemical peels
- Botox
- Fillers

Have you tanned in a tanning bed/sun/spray in the past 4 weeks? _____

Have you used accutane? _____ when? _____

Have you ever had cold sores/fever blisters? _____

Are you currently on a skin care regimen? _____

Do you smoke? _____

Do you have allergies to skin care? _____

Are you on hormone replacement therapy? _____

Are you pregnant or breast feeding? _____

Have you ever had a keloid scar? _____

Are you currently on aspirin therapy? _____

ENLIGHTEN CANCELLATION POLICY

Our goal at Enlighten is to give our patients the utmost of attention and care. Time is valuable to everyone. Our office requires a 24 business hour advance notice of a cancellation of a scheduled appointment. Failure to do so will result in a fee of \$50.00. We understand that emergencies do occur, and we will take those into consideration. We hope that if at possible, you will notify us prior to your appointment time. We hope, however, that this policy will reduce confusion, delay, and improve the attention that we are able to provide. We appreciate your cooperation and understanding. In the event of multiple missed appointments, you will be charged the full amount of your missed service.

Thank you,
Enlighten staff

Patient _____ Date _____

Witness _____ Date _____

REFUND POICY

All packages sales are final, refunds on package purchases will not be given. Packages include hair removal, Photofacial (IPL), Fractional resurfacing, dermal infusions or leg veins. Due to the nature of the treatments and the way packages are sold it is not possible to refund money on partially completed treatments. Exchanges may be made on certain services with approval. Thank you for your understanding.

Patient _____ date _____

Witness _____ date _____

INFORMED CONSENT TO BOTULINUM TOXIN INJECTION
(BOTULINUM TOXIN TYPE-A AS BOTOX FROM ALLERGAN)

FOR THE TEMPORARY TREATMENT OF SUPERFICIAL FACIAL WRINKLES

Please initial after each statement and sign at the bottom.

Botox is botulinum toxin type-A and it works by interrupting communication between nerves and muscles causing temporary paralyzation of muscle.

1. I consent to treatment of facial wrinkles with Botox. _____
2. The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction. _____
3. I understand surgery or other treatment alternatives may be as effective or more effective in reducing the appearance of wrinkles. _____
4. 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. _____

The known complications could include:

- Redness, swelling/edema, itching, pain or pressure lasting more than one week
- Temporary nodules or induration at the injection site
- Temporary discoloration of the injection site
- Allergic reactions
- Bruising
- Facial asymmetry
- Paralysis leading to temporary droopy eyelid and double vision
- Some patients may experience weakness or flu-like symptoms
- Rare cases of developing antibodies to Botox

5. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to Botox. _____
6. I certify that I have read this entire informed consent and that I understand and agree to the information stated in this 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. _____
7. No guarantee, warranty or assurance has been made as to the treatment results. _____
8. Botox usually takes effect in 3-5 days but can take a full 2 weeks to take affect. Results usually are 3-4 months but can be less. _____

9. I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including:_____

- No laying down or reclining for four hours after injection
- No scratching or rubbing the injected area
- No bending forward for four hours
- Do not manipulate the area (ie. Facial) for four hours
- No strenuous exercise for four hours

Patient Name (please print) _____

Signature _____ Date _____

Witness Signature _____ Date _____

**INFORMED PATIENT CONSENT FOR TREATMENT
WITH INJECTABLE FILLERS**

My signature and initials after each statement below constitutes my acknowledgement that:

1. I consent to treatment with injectable filler to improve the appearance of scars and/or wrinkles, or to have lips augmented (made larger). The filler to be used is Juvederm.

2. The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction. _____
3. I am fully aware of the risks of complications or injuries that can occur from this treatment, both the known and unknown causes, and I freely assume those risks.

The known complications may include:

- Redness, swelling/edema, itching, pain or pressure lasting more than one week
- Temporary nodules or induration at the injection site
- Temporary discoloration of the injection site
- Allergic reactions
- Poor effect or weak filling

4. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophic scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to hyaluronic acid.
5. I certify that I have read this entire informed consent and that I understand and agree to the information stated in this 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 parents/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 representation, heirs, administrators, successors, and assigns. _____
6. I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including: _____
7. No guarantee, warranty or assurance has been made as to the treatment results.

8. 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. _____

Patient Name (please print) _____

Signature _____

Date _____

Witness Signature _____

Date _____