Pascia & Pascia Dentistry
David T. Pascia D.M.D.

Informed Consent for Botulinum Toxin Treatment

The purpose of this informed consent form is to provide written information regarding the risks, benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your Dentist.

Patient Name: _____ **Birthday:** _____

It is important that you fully understand everything listed below, so please read the document thoroughly. If you have any questions regarding the procedure, ask your Dentist prior to signing this consent form.
***Please initial next to each section once read and understood. If you have any questions, please wait to initial on that section till your questions are fully answered.**

THE TREATMENT

Botulinum toxin (Botox®, Xeomin®, and similar agents) is a neurotoxin produced by the bacterium Clostridium A. Botulinum toxin can relax the muscles on areas of the face and neck which cause wrinkles associated with facial expressions or facial pain. Treatment with botulinum toxin can cause your facial expression lines or wrinkles to be less noticeable or essentially disappear. Areas most frequently treated are: A) Glabellar area of frown lines, located between the eyes; B) Crow's feet (lateral areas of the eyes); C) Forehead wrinkles; D) Radial lip lines (smokers lines), E) Head and neck muscles. Botox is diluted to a very controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Patients may feel a slight burning sensation while the solution is being injected. The procedure takes about 20-30 minutes and the results can last up to 3 months. With repeated treatments, the results may tend to last longer.

Initial _____

RISKS AND COMPLICATIONS

Before undergoing this procedure, understanding the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risks that are not included on this list. Some of these risks, if they occur, may necessitate hospitalization, and/or extended outpatient therapy to permit adequate treatment. 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, and bruising, 2. Double vision, 3. A weakened tear duct, 4. Post treatment bacterial, and/or fungal infection requiring further treatment, 5. Allergic reaction, 6. Minor temporary droop of eyelid(s) in approximately 2% of injections, this usually lasts 2-3 weeks, 7. Occasional numbness of the forehead lasting up to 2-3 weeks, 8. Transient headache and 9. Flu-like symptoms may occur.

Initial _____

PREGNANCY, ALLERGIES, & NEUROLOGIC DISEASE

I am not aware that I am pregnant and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenis gravis, multiple sclerosis, lambert-eaton syndrome, amyotrophic lateral sclerosis (ALS), and parkinson's. I do not have any allergies to the toxin ingredients, or to human albumin.

Initial _____

ALTERNATIVE PROCEDURES

Alternatives to the procedures and any other options have been fully explained to me.

Initial _____

PAYMENT

I understand that this is an elective procedure and that payment is my responsibility and is to be paid in full at the time of treatment.

Initial _____

RIGHT TO DISCONTINUE TREATMENT

I understand that I have the right to discontinue treatment at any time.

Initial _____

PHOTOGRAPHS

I authorize the taking of any photographs to be taken of all sites treated, which will be used to document my medical records. I understand my name shall not be used in any publication of pictures taken. I understand before and after photos will be taken. I understand that photographs and video may be taken of me for educational and marketing purposes. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs

Initial _____

PRE & POST OP INSTRUCTIONS

I have read through and understand the Pre & Post treatment instructions.

Initial _____

RESULTS

I am aware that when small amounts of purified botulinum toxin are injected into a muscle it causes weakness or paralysis of that muscle. This appears in 2 – 10 days and usually lasts up to 3 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 and there are some individuals who do not respond at all. I understand that I will not be able to use the muscles injected as before 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 (s) of the injections for the 2 hours post-injection period.

Initial _____

COSMETIC INJECTIONS

For this and all future injections of Botox® and/or Xeomin®, I understand that:

- I will be injected with the utmost skill and care.
- Each person's body reacts differently. The effect of the injection may not be exactly the same every time.
- No guarantees are made regarding the results or their longevity.
- Touch-ups will incur an additional charge per unit.
- No refunds will be made.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with botulinum toxin injections for facial dynamic wrinkles, TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment performed is between me and the doctor/healthcare provider who is treating me and I will direct all post-operative questions or concerns to the treating clinician. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure and I understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history I will notify the doctor/healthcare professional who treated me immediately. I also state that I read and write in English.

I have fully read this consent form and understand everything.

Patient Name Printed: _____

Patient Signature: _____ Today's Date: _____

Office Use Below:

*Dental Head & Neck examination completed – Date: _____ Dentist Initials: _____

I am the treating Dentist. I discussed the above risks, benefits, and alternatives with the patient. The patient had an opportunity to have all questions answered and was offered a copy of this informed consent. The patient has been told to contact my office should they have any questions or concerns after this treatment procedure.

Dentist Name: David T. Pascia D.M.D - Treating Dentist Signature: _____ Today's Date: _____

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Botox® and Xeomin® Pre-Treatment and Day Of Instructions & Information

PRE-TREAMENT

- 3 DAYS BEFORE treatment: Avoid topical products such as Tretinoin (Retin-A), Retinols, Retinoids, Glycolic Acid, Alpha Hydroxy Acid, or other "anti-aging" products. Also AVOID waxing, bleaching, tweezing, or the use of hair removal cream on the area to be treated.
- IDEALLY, 2 WEEKS BEFORE, IF NOT, AT LEAST 7 DAYS BEFORE treatment (to help with prevention of bruising/swelling): AVOID anti-inflammatory/blood thinning over-the-counter medications such as *Aspirin, Mortrin, Ibuprofen, and Aleve.* Also avoid herbal supplements, such as *Garlic, Vitamin E, Ginkgo Biloba, St. John's Wort,* and *Omega-3* capsules.
- Do not drink alcoholic beverages 24 hours before (or after) your treatment to avoid extra bruising.
- Do not use Botox® or Xeomin® if you are pregnant or breastfeeding, are allergic to any of its ingredients, or suffer from neurological disorders. Please inform your Dentist if you have any questions about this prior to treatment.
- Patient should not be a needle phobic
- Be sure to have a good breakfast including food and drink before your procedure. This will decrease the chances of lightheadedness during your treatment.
- Make sure you schedule Botox® and Xeomin® appointments at least 2 weeks prior to a special event which you may be attending, such as a wedding, vacation, etc. Bruising and swelling may be apparent in the first 4-7 days.

DAY OF TREATMENT

- Arrive to the office with a "clean face". Please **DO NOT WEAR ANY MAKEUP.** You may bring your own makeup to apply lightly 2-4 hours following treatment.
- You may experience a mild amount of tenderness or a slight stinging sensation following injection.
- Redness and swelling are normal. Some bruising may also be visible.
- You may experience some tenderness at the treatment site(s) that can last for a few hours or a few days. You may have some bruising in those treated areas.

I have reviewed all the Pre-Treatment Instructions and Day of Treatment Instructions and fully understand.

Patient Name Printed:_____

Patient Signature: _____ **Today's Date:**_____

2143 49th St. North – St. Petersburg, FL 33710 – (727)321-1900

Pascia & Pascia Dentistry
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Botox® and Xeomin® Post Treatment Instructions & Information

The guidelines to follow post treatment have been followed for years, and are still employed today to prevent the possible side effect of ptosis (drooping of the eyelids & eyebrows). These measures should minimize the possibility.

1. **AVOID exercise and/or strenuous activities** for the remainder of the treatment day; you may resume other normal activities/routines immediately.
2. **DO NOT** rub or manipulate the area that has been injected with the Botox® or Xeomin® solution. This can result in migration from the targeted muscle and can lead to brow or eyelid prtosis (drooping of the eyelids & eyebrows)
3. **DO NOT** lie flat or move into a forward bending position for 4 hours after the procedure. Lying down (as for a nap, or to rest your head) as this can cause the solution to migrate from the targeted muscle and lead to complications.
4. **DO** exercise the muscle that has been injected with the Botox® or Xeomin® solution for 1-2 hours after the procedure. This is to stimulate the binding of the product only in the localized area.
5. It is ideal to wear limited to no makeup up to 2-4 hours after treatment is completed. **AVOID placing excessive pressure on the treated area(s)** for the first few days; when cleansing your face or applying makeup, *be very gentle.*
6. Although some patients may experience minimal treatment effect in 48-72 hours, most patients do not notice full treatment effective for 7-14 days following the treatment. **Please allow 2 full weeks to allow everything to reach its full potential. You will be scheduled for a follow up appointment 2 weeks following treatment. At that follow up appointment, if any more Botox® or Xeomin® is needed (per patient request) and/or recommended (By Dr. David T. Pascia), there will be an additional charge per unit.
7. Although extremely rare, allergic reaction to Botox® and/or Xeomin® serum can occur. If you experience EXTREME skin redness, swelling or rash, or SEVERLY swollen or puffy eyes, or SEVERE headache, you may be allergic to Botox® and/or Xeomin®, or you may have developed antibodies to the Botox® and/or Xeomin serum from previous treatment. If during office hours, please call the office and schedule an appointment to be seen by the doctor. If it is after hours, or true emergency, please go to the closet emergency room.
8. Since bruising and minor swelling can occur at the injection site, it is advisable to not have any major scheduled events for the 2 weeks following treatment.

After treatment, if you have any questions, concerns, or experience any problems, please call the office at (727)321-1900.

I understand the Post-Op Instructions/Information

Patient Name Printed:_____

Patient Signature: _____ **Today's Date:**_____