Lawrence M. Bodenstein D.M.D.
253 Boulevard, Suite 1
Hasbrouck Heights, NJ 07604
(201) 288-1788

Name________________________________ DOB________________________________

Home Phone__________________________ Cell_________________________________

Home Address____

Email____

Who do we have to thank for your referral?____

Please list the following

ALLERGIES: ____

Aids/HIV Positive	Y	N	Cortisone Medicine	Y	N	Hemophilia	Y	N	Radiation Treatments	Y	N
Alzheimer's Disease	Y	N	Diabetes	Y	N	Hepatitis A	Y	N	Recent Weight Loss	Y	N
Anaphylaxis	Y	N	Drug Addiction	Y	N	Hepatitis B or C	Y	N	Renal Dialysis	Y	N
Anemia	Y	N	Easily Winded	Y	N	Herpes	Y	N	Rheumatic Fever	Y	N
Angina	Y	N	Emphysema	Y	N	High Blood Pressure	Y	N	Rheumatism	Y	N
Arthritis/Gout	Y	N	Epilepsy or Seizures	Y	N	High Cholesterol	Y	N	Scarlet Fever	Y	N
Artificial Heart Valve	Y	N	Excessive Bleeding	Y	N	Hives or Rash	Y	N	Shingles	Y	N
Asthma	Y	N	Excessive Thirst	Y	N	Hypoglycemia	Y	N	Sickle Cell Disease	Y	N
Autoimmune Disease	Y	N	Fainting Spells/Dizziness	Y	N	Irregular Heartbeat	Y	N	Sinus Trouble	Y	N
Blood Disease	Y	N	Frequent Cough	Y	N	Kidney Problems	Y	N	Spine Bifida	Y	N
BLOOD Transfusion	Y	N	Frequent Diarrhea	Y	N	Leukemia	Y	N	Stomach/Intestinal Disease	Y	N
Breathing Problems	Y	N	Frequent Headaches	Y	N	Liver Disease	Y	N	Stroke	Y	N
Bruise Easily	Y	N	Genital Herpes	Y	N	Low Blood Pressure	Y	N	Swelling of Limbs	Y	N
Cancer	Y	N	Glaucoma	Y	N	Lung Disease	Y	N	Thyroid Disease	Y	N
Chemotherapy	Y	N	Hay Fever	Y	N	Mitral Valve Prolapse	Y	N	Tonsillitis	Y	N
Chest Pains	Y	N	Heart Attack/Failure	Y	N	Osteoporosis	Y	N	Tuberculosis	Y	N
Cold Sores/Fever Blisters	Y	N	Heart Murmur	Y	N	Pain in Jaw Joints	Y	N	Tumors or Growths	Y	N
Congenital Heart Disorder	Y	N	Heart Pacemaker	Y	N	Parathyroid Disease	Y	N	Ulcers	Y	N
Convulsions	Y	N	Heart Trouble/Disease	Y	N	Psychiatric Care	Y	N	Venereal Disease	Y	N
									Yellow Jaundice	Y	N

Have you ever had any serious illness not list above?
____

Are you pregnant? ___________

Signature______________________________________ Date_____________

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Botox, Dysport and Xeomin Consent Form

Please read and sign below:

Initial _____ **Indications and alternatives:** Botox, Dysport or Xeomin, a neurotoxin that blocks messages between muscles and the nerves that control them. The effects of Botox, Dysport or Xeomin become apparent 2-5 days after injection and generally last for 3-5 months. The FDA has approved the use of Botox, Dysport or Xeomin to treat facial dystonias (spasms), strabismus (crossed eyes), and to temporarily soften facial rhytids (wrinkles) between the eyebrows. While the FDA has not approved injections to improve the appearance of wrinkles in other areas of the face, physicians may perform these "off-label" procedures. There are alternatives to Botox, Dysport or Xeomin, including no treatment, or medicines or surgery on my facial nerves and muscles.

Initial _____ **Side effects and complications include but are not limited to:** Bruising, Undercorrection (not enough effect) or Overcorrection (too much effect), Facial asymmetry (one side looks different than the other), Paralysis of a nearby muscle leading to: droopy eyelid, double vision, inability to close eye, difficulty whistling or drinking from a straw, Generalized weakness, Permanent loss of muscle tone with repeated injection, Flu-like syndrome or respiratory infection, Nausea or headache, Development of antibodies to Botox.

Initial _____ **Contraindications:** You should not have Botox, Dysport or Xeomin if: you are pregnant; nursing; allergic to albumin; have an infection, skin condition, or muscle weakness at the site of the injection; or have Eaton-Lambert syndrome, Lou Gehrig's disease, or myasthenia gravis. I understand the above, and have had the risks, benefits, and alternatives explained to me. No guarantees about results have been made. I give my informed consent for Botox, Dysport or Xeomin injections today as well as future treatments as needed.

Initial _____ **PHOTOGRAPHS**: I authorize the taking of photographs and their use for documentation purposes. I understand my identity will be protected.

Initial _____ **DISCLAIMER:** Informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your provider may provide you with additional or different information which is based on all of the facts pertaining to your particular case and the state of medical knowledge. Informed-consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. It is important that you read the above information carefully and have all of your questions answered before signing the consent.

LIST OF POSSIBLE SIDE EFFECTS:

Dry eye problems- Individuals who normally have dry eyes may be advised to use special caution in considering Botox, Dysport or Xeomin injections around the eyelid region.

Migration of BOTOX- Botox, Dysport or Xeomin may migrate from its original injection site to other areas and produce temporary paralysis of other muscle groups or other unintended effects.

Drooping Eyelid (Ptosis) - Muscles that raise the eyelid may be affected by Botox, Dysport or Xeomin , should this material migrate downward from other injection areas.

Double-Vision -Double-vision may be produced if the Botox, Dysport or Xeomin material migrates into the region of muscles that control movements of the eyeball.

Eyelid Ectropion- Abnormal looseness of the lower eyelid can occur following Botox, Dysport or Xeomininjection.

Asymmetry-The human face and eyelid region is normally asymmetrical with respect to structural anatomy and function. There can be a variation from one side to the other in terms of the response to Botox, Dysport or Xeomin injection.

Unsatisfactory result-There is the possibility of a poor or inadequate response from Botox, Dysport or Xeomin injection. Additional injections may be necessary. Surgical procedures or treatments may be needed to improve skin wrinkles including those caused by muscle activity.

Allergic reactions-As with all biologic products, allergic and systemic anaphylactic reactions may occur. Allergic reactions may require additional treatment.

Antibodies to BOTOX- Presence of antibodies to Botox, Dysport or Xeomin may reduce the effectiveness of this material in subsequent injections. The health significance of antibodies to Botox, Dysport or Xeomin is unknown.

Infection- Infection is extremely rare after Botox, Dysport or Xeomin injection. Should an infection occur, additional treatment including antibiotics may be necessary.

Long-term effects- Subsequent alterations in face and eyelid appearance may occur as the result of aging, weight loss of gain, sun exposure, or other circumstances not related to Botox, Dysport or Xeomin injections. Botox, Dysport or Xeomin injections do not arrest the aging process or produce permanent tightening of the eyelid region. Future surgery or other treatments may be necessary.

Pregnancy and nursing mothers- Animal reproduction studies have not been performed to determine if Botox, Dysport or Xeomin could produce fetal harm. It is not known if Botox, Dysport or Xeomin can be excreted in human milk.

Drug Interactions- The effect of Botox, Dysport or Xeomin may be potentiated by aminoglycoside antibiotics or other drugs known to interfere with neuromuscular transmission.

Patient Name: ________________________________

Patient Signature: _____________________________ Date: ___________

Patient Signature: _____________________________ Date____________

Patient Signature: _____________________________ Date____________

Patient Signature: _____________________________ Date____________

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Hyaluronic Acid Facial Filler Consent Form

Juvederm, Perlane, Restylane, Belotero and Voluma

Please read and sign below:

I authorize the injection of the facial filler to improve unsightly wrinkles or folds or add volume to my face. I understand these synthetic fillers are widely used in many countries around the world, are extremely safe, and are approved by the U.S. FDA. In addition, there is no need for skin testing prior to use; allergic reactions are extremely rare.

I understand that while all these fillers achieve the same results, there are differences in their composition as follows: Restylane/Perlane/Juvederm/Belotero/Voluma are hyaluronic acids.

I understand that this is an elective procedure, at my request for the elimination of facial wrinkles or depressions in my skin, and is being performed for the improvement of my appearance. I understand that follow up treatments may be required for optimal results and that insurance will not cover the cost of the procedure. I also understand that there may be a need for further procedures to receive optimal results and that there will be additional charge for subsequent treatment.

I have been told that minor side effects are common and include temporary bruising and pain, redness and swelling which may last for a few days. Other potential risks include under correction or over correction of the problem being treated, facial asymmetry or the development of small nodules under the surface of the skin, serious or long lasting effects are very rare. I also understand the results of filler treatment are temporary and will wear off within 4-12 months depending on the filler used. I also understand that my appearance will return to what it was before the treatment started.

Risks and complications that may be associated with facial fillers and the injection procedure include, but are not limited to:

- Accidental Injection into a Blood Vessel
- Infection
- Recurrence of Herpes Infection
- Allergic Reactions
- Migration
- Keloids/Scarring

Initial ______ I understand and agree to not manipulate the area which has been injected, and will contact my physician if I feel this needs to be done.

Initial ______ I consent to photographs being taken during the course of my treatment to evaluate the effectiveness of the treatment and they may also be used for teaching and training purposes for other professionals.

Pre-treatment and post-treatment instructions have been given to me and the potential advantages and disadvantages have been discussed with me. I have had all of my questions answered and I freely consent to the proposed treatment. I agree to not hold any staff responsible for any complications which may occur.

Initial ____ I am not pregnant.

Initial _____ I am not allergic to lidocaine.

Patient Name: ________________________________

Patient Signature: ______________________________ Date: ____________

Witness Signature: ______________________________ Date: ____________

Patient Signature: ______________________________ Date____________

Patient Signature: ______________________________ Date____________

Patient Signature: ______________________________ Date____________

Patient Signature: ______________________________ Date____________

Patient Signature: ______________________________ Date____________

Patient Signature: ______________________________ Date____________

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully and acknowledge receipt by your signature at the end of this notice.

This notice describes how the Dr. Bodenstein may use and disclose your protected health information. The Dr. Bodenstein will share patient health information as is necessary to provide quality health care. The Dr. Bodenstein is required by law to maintain the privacy of our patient's health information and to provide patients with this Notice so long as it remains in effect and we reserve the right to change the terms of this Notice of Privacy Practices as necessary. A copy of any revised notices will be mailed to your address maintained on file.

Uses and Disclosures of Your Health Information

The Dr. Bodenstein is committed to maintain the confidentiality of your health information. However, your health information may be used and disclosed is customary and reasonable for purposes of treatment, payment, and health care operations and pursuant to a signed authorization form. You have the right to revoke that authorization in writing unless any action has been taken in reliance on the authorization.

Treatment, Payment, and Health Care Operations

(Except as otherwise provided, or with your signed consent), the Dr. Bodenstein will use and disclose your health information for purposes of treatment, payment, and as otherwise necessary and permitted by law, for our health care operations. This may include disclosure to other health care providers who, at the request of your physician, becomes involved in your treatment.

Business Associates

At times, it may be necessary for us to provide your health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, legal services, etc. These business associates are required to properly safeguard the privacy of your health information.

Family and Friends

With your approval and using our professional judgment, your health information may be disclosed to designated family, friends, and others who are directly involved in your care or payment of your care. If you are unavailable, incapacitated, or in an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited health information with such individuals without your approval.

When your information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by federal HIPPA Privacy Rule. You have the right to revoke this authorization in writing except when the Dr. Bodenstein has acted in reliance upon this authorization. Your written revocation must be submitted to our office at 253 Boulevard, Suite 1, Hasbrouck Heights, N.J.,07604.

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Printed Name of Patient

______________________________________ ____________________________

Signature of Patient Date