DR. ROBERT APPLEBAUM

BOARD CERTIFIED - AMERICAN BOARD OF PLASTIC SURGERY
BEVERLY HILLS, CALIFORNIA

Patient's Name ____
Last First Middle Initial

Home Address ______________________________ City ______________

State __________ Zip Code _________ Date of Birth ____________ Age ________ Sex: Female Male

Home Phone # ________________________ Work Phone # ________________________

E-Mail ______________________________ Cell Phone # ___________________________

Occupation ______________ Whom may we thank for referring you to this office? ______________

Patient Profile

Are you taking prescription blood thinners? ☐ Yes ☐ No

Are you currently taking Aspirin? ☐ Yes ☐ No

Are you pregnant or lactating? ☐ Yes ☐ No

Have you ever had dermal filler injections? ☐ Yes ☐ No

Have you ever had Botox injections? ☐ Yes ☐ No

Do you smoke cigarettes? ☐ Yes ☐ No

If yes, how much do you smoke? ☐ Yes ☐ No

Facial Surgery History

Have you had any facial implants? ☐ Yes ☐ No

Please list any prior facial surgery including laser resurfacing:

Procedure________________ Date__________

Procedure________________ Date__________

Procedure________________ Date__________

Allergies to Medications:

____

____

____

List Current Prescription Medications:

____

____

____

Medical History

Please check the boxes that apply to your medical history.

Hypertension ☐

Heart Disease ☐

Diabetes ☐

Stroke ☐

Lupus ☐

Hepatitis ☐

Patient Signature: ______________________________**Date:** ______________

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PERSONAL HEALTH INFORMATION FORM

ROBERT APPLEBAUM, M.D.
SYLVIE LEMAY, R.N.
FOUR THIRTY SIX AESTHETIC SURGERY CENTER

As per HIPPA rules and regulations you are required to inform this office how you would like us to communicate with you in regards to your Personal Health Information (PHI). Our office may need to contact you to confirm your appointment, schedule surgery, return your phone calls or to give you results of labs, x-rays, scans, or other medical testing. Per HIPPA we are required to follow your written instructions , except where we feel following the instructions would be detrimental to your health or in case of emergency.

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.

You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

Please be specific as to how we are to reach you, where we can leave messages and with whom.
Please fill in or circle:

You may / may not call me at my home phone number: _________________________________

You may / may not leave a message on my home answering machine. You may leave a message with (please circle) no one, my spouse, my children, other: ______________________________

You may / may not call me on my cell phone number.

You may / may not leave a message on my cell phone voice mail.

You may change your decision at any time by filing a request form change and fax it to us at (310) 550-8822.

Patients Signature (or Personal Representative)

_______________________________________ Date: _____________

Printed name of representative / relationship with Patient

_______________________________________ Date: _____________

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INFORMED CONSENT FOR COSMETIC INJECTABLES

I (Print Name) ______________________________________have requested that **Dr. Applebaum/ Sylvie Lemay-Levy R.N.** inject my face with one of the following **HYALURONIC ACID GEL FILLERS** (Juvederm, Restylane, Perlane). Injectable hyaluronic gel is a colorless gel that is injected into facial tissue to smooth wrinkles and folds and add volume to various area of the face. Hyaluronic acid is a naturally occurring sugar found in the human body. All of the above injectable gel fillers temporarily add volume to facial tissue and restore a smoother appearance to the face. Since correction is temporary (4-8 months); therefore, touch-up injections as well as repeat injections are usually needed to maintain optimal correction. **Most side effects are mild or moderate in nature, and their duration is short lasting (7 days or less). The most common side effects include, but are not limited to temporary injection site reactions such as: redness, pain/tenderness, firmness, swelling, lumps/bumps, bruising, itching, and discoloration**. As with all skin injection procedures there is a risk of infection and scarring in rare instances. Hyaluronic acid gel fillers should not be used in patients who have: severe allergies marked by a history of anaphylaxis or history or presence of multiple severe allergies or patients with a history of allergies to gram-positive bacterial proteins. The following are important treatment considerations: Patients who are using substances that can prolong bleeding, such as aspirin or ibuprofen, as with any injection, may experience increased bruising or bleeding at injection site. You should inform your physician before treatment if you are using these types of substances. The safety of hyaluronic acid gel fillers for use during pregnancy, in breastfeeding females or in patients under 18 years has not been established. The safety and effectiveness of hyaluronic acid gel fillers for the treatment of areas other than facial wrinkles and folds (such as lips) have not been established in controlled clinical studies. Be sure to report any redness and/or visible swelling that lasts for more than a few days or any other symptoms that cause you concern to your physician. I have read the information titled "Informed Consent for **HYALURONIC ACID GEL FILLERS**" in its entirety and have discussed the risks and benefits of dermal filler treatment with my physician and his I agree to my being treated /her representative. I give my consent for treatment will a hyaluronic acid gel filler. The fees paid for this service are **non-refundable**.

I _______________________________________have requested that **Dr. Applebaum/ Sylvie Lemay-Levy R.N**.treat my facial lines with **BOTOX or DYSPORT** (Neuromuscular blocking agents). Neuromuscular blocking agents are approved by the FDA to improve the appearance of the vertical lines between the brows. A few tiny injections of neuromuscular blocking agents relax overactive muscles and soften those vertical lines. Injections in other areas to improve appearance of facial lines have been reported in the literature, but the FDA has not approved those uses. The results of these agents are usually dramatic, although the practice of medicine is not an exact science and no guarantees can be or have been made concerning expected results. The product itself is very expensive and for this reason the fees paid for this service are non-refundable. The **BOTOX and DYSPORT** solutions are injected with a tiny needle into the muscle; you should see the benefits develop over the next two to seven days. A decreased appearance of frowning or creasing of other lines will be the result of this treatment. **The most common side effects are headache, respiratory infection, flu syndrome, temporary eyelid droop, and nausea.** Neuromuscular blocking agents should not be used if there is an infection at the injection site. I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all. I understand that the results are temporary and several sessions may be needed for optimal results. I agree that this constitutes full disclosure. I certify that I have read, and fully understand, the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions. I consent to this **BOTOX / DYSPORT** treatment today and for all subsequent treatments.

INFORMED CONSENT FOR COSMETIC INJECTABLES SIGNATURE PAGE

Patient Signature:________________________________ Date:____________________________

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