Johnson Family Medical
469-656-4602
www.johnsonfamilymedical.com

JOHNSON FAMILY MEDICAL

12530 Lebanon Rd
#202
Frisco, TX 75035

Aesthetic Questionnaire

Allergies

☐ Cow Milk, Eggs, Other Animal Proteins ☐ History of Anaphylaxis or Multiple Severe Allergies
☐ Allergy to Gram-Positive Bacteria ☐ Latex ☐ Lidocaine ☐ "Caines" ☐ Hydrocortisone ☐ Aspirin ☐ Reaction to previous botulism toxin treatment products (Botox, Dysport, Jeuveau)

Food Allergies: _____ Other Allergies: _____

General Health

Any Dental Work in the past or upcoming 2 weeks? ☐ Yes ☐ No If yes, describe: _____
Any Chronic or Other Health Conditions? ☐ Yes ☐ No If yes, describe: _____
_____

Aesthetic Treatment History

Any Facial Surgery Within Past 6 Months? ☐ Yes ☐ No If yes, describe: _____
_____
Do you form thick or raised scars from Burns / Cuts / Surgery? ☐ Yes ☐

No Do you bruise easily? ☐ Yes ☐ No
Have you ever experienced eyelid droop after Botox or similar product? ☐ Yes ☐ No
Do you get lightheaded or pass out easily, especially with injections? ☐ Yes ☐ No
Have you ever experienced complications with Botox (or similar products) or Fillers? ☐ Yes ☐ No
Describe: _____
Most recent Botulinum Toxin: Product: _____ Area: _____Date: _____
Most recent Fillers: Product: _____ Area: _____Date: _____
Most recent Micro Needling Date: _____

For Female Clients: Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
Are you currently breastfeeding? ☐ Yes ☐ No

Additional information you would like the healthcare professional to know:

_____
_____

I certify that the preceding medical, medication, and personal history statements are true and correct. I am aware that it is my responsibility to inform the healthcare professional of my current and past medical and health conditions and to update this history.

Patient Name (Print): _____

Patient Signature: _____ Date: _____/_____/_____

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COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective treatment / procedure / surgery that is not urgent and is not determined to be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. James E. Race, MD (Medical Director), and Katherine Johnson, FNP, and Anne Bechtold, RN, and all the staff at Johnson Family Medical are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment / procedure / surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. James E. Race, MD (Medical Director), and Katherine Johnson, FNP, and Anne Bechtold, RN, and all the staff at Johnson Family Medical to proceed with the same.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment / procedure / surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before / during / after my treatment / procedure / surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine / self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation / ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment / procedure / surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment / procedure / surgery itself.

I have been given the option to defer my treatment / procedure / surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I choose to proceed with my desired treatment / procedure / surgery.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE(S).

_____ Date: _____/_____/_____

Patient or Person Authorized to Sign for Patient

_____ Date: _____/_____/_____

Witness Date / Time

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Neurotoxin Cosmetic Treatment Consent

I understand that Neurotoxins are FDA approved prescription medications used to improve the vertical lines between the brows, known as the glabella region, forehead, and lateral aspects of the eyes, commonly referred to as “crow’s feet.” In addition, Neurotoxins are used “off label” in many cosmetic procedures to soften lines and reduce wrinkles on the lips, and other facial regions as a “standard of practice” in the medical community. Reduction of fine lines and wrinkles are achieved by injecting *Botulinum Toxin A,* which temporarily paralyzes the injected muscle, preventing communication from the nerve to the desired muscle. I understand that *Botulinum Toxin A* has been safely used for over 25 years and is injected in the recommended ratio provided by the manufacturer.

I understand that results may vary due to the variation of facial composition. Results can take up to 2 weeks to appear. Repeated use is known to possibly yield faster and more sustained results. Results tend to improve over time. Men and first-time users typically require more of the product for optimal results. Touch ups may be needed, and I understand and acknowledge they must be done within a 10-14-day window and not beyond. I acknowledge touch ups are charged at the same rate as the original treatment being touched up.

I understand that the reduction in wrinkles is not guaranteed or permanent, and subsequent treatments are required to maintain the desired result. Once injected, the product is metabolized within 24-48 hours. I understand that results last an average of 3 to 4 months. I also understand there is a small percentage of the population that *Botulinum Toxin A* has very little or **no effect** and this cannot be determined in advance of injection.

I understand that the most common side effects are discomfort at injection site, bruising, and headache. Other side effects include nausea, flu-like symptoms, temporary eyelid droop, respiratory infection, damage to deeper structures, dry eye problems, migration of Neurotoxins, asymmetry, pain, allergic reaction, infection, skin disorders, neuromuscular disorders, unsatisfactory result, drug interaction, and, rarely, double vision or other unknown risks. *Neurotoxins should not be used if there is an infection at the injection site, in people with neuromuscular disorders, allergies to egg and/or milk**, or pregnant or nursing woman.***

I hereby give consent to receive on/off label treatment with *Botulinum Toxin A* (Neurotoxins) for the temporary reduction of wrinkles. **By signing this consent, I am stating I do not by my knowledge have any of the contraindications listed and underlined above**. I understand that this is an elective treatment for cosmetic purposes only and no guarantees or warranties have been expressed or implied. I have been given, and discussed, other treatment options, including no treatment and surgical intervention. I choose to have this treatment done. I hereby release and hold harmless Dr. James E. Race, MD (Medical Director), L. Anne Bechtold, RN, Katherine Johnson, FNP, and Johnson Family Medical from liability for any of the possible side effects, which have been explained to me in full resulting from the aforementioned procedure.

IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:

A) THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
B) THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
C) THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

_____ Date: _____/_____/_____

Patient or Person Authorized to Sign for Patient

_____ Date: _____/_____/_____

Witness Date / Time

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PHOTO/VIDEO RELEASE AGREEMENT

I, the undersigned, do hereby agree to the following with Dr. James E. Race, MD (Medical Director), and Katherine Johnson, FNP, and any employee or contractor hired by Johnson Family Medical, hereafter referred to as “Providers”: (Please initial all that apply below)

I authorize Providers to take photos of my treatment and/or treated areas to be used for the following purposes outlined below. I understand that in order to receive treatment, photos must be taken.

- Providers must take photos/videos of my treatment and/or treatment areas before, during, and after treatment is provided in order to document progress and chart events for internal use of the practice.
- Providers must take photos/videos of my treatment and/or treatment areas before, during, and after treatment is provided to be used for education / training purposes for internal use of the practice.
- Providers must take photos/videos of my treatment and/or treatment areas before, during, and after treatment is provided to be used for advertising and/or marketing purposes to help educate others of the results they may expect from similar treatments.

I understand my likeness may be used (photo/video) on the internet, social media, promotions, advertising, and other print and/or electronic media. This permission shall continue in perpetuity.

I hereby waive the right to receive any payment and waive the right to receive any payment from Providers for use of any of the material described above or any of the purposes authorized by this release. I also waive any right to inspect or approve any of the material or uses described above.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PHOTO/VIDEO AGREEMENT AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION.

Patient Name (Print): _____

Patient Signature: _____ Date: _____/_____/_____