WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B. : _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other _____	

Are you currently under drug and/or medical care? ❑ Yes ❑ No If yes, explain _____

Please list any medications you are currently taking (**Be sure to include dosage and frequency**) _____

_____

Please list any surgeries and/or hospitalizations you have had (**type & date**): _____

_____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease _____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Superior HealthCare. (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights. I may speak with the Privacy Officer about my concerns.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Witness (Office Staff) Date

ROBERTSON COUNTY
PHYSICAL MEDICINE

Botulinum Toxin Type A: Botox® Cosmetic & Dysport® Consent Form

BOTOX® Cosmetic is indicated for the temporary improvement in the appearance of moderate to severe glabellar lines associated with corrugator and/or procerus muscle activity in adult patients ≤ 65 years of age.

BOTOX® Cosmetic (onabotulinumtoxinA) for injection, is a sterile, vacuum-dried purified botulinum toxin type A, produced from fermentation of Hall strain Clostridium botulinum type A grown in a medium containing casein hydrolysate, glucose, and yeast extract, intended for intramuscular use. BOTOX® Cosmetic blocks neuromuscular transmission by binding to acceptor sites on motor nerve terminals, entering the nerve terminals, and inhibiting the release of acetylcholine. This inhibition occurs as the neurotoxin cleaves SNAP-25, a protein integral to the successful docking and release of acetylcholine from vesicles situated within nerve endings. When injected intramuscularly at therapeutic doses, BOTOX® Cosmetic produces partial chemical denervation of the muscle resulting in a localized reduction in muscle activity.

Administration of BOTOX® Cosmetic is not recommended during pregnancy. There are no adequate and well-controlled studies of BOTOX® Cosmetic in pregnant women. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when BOTOX® Cosmetic is administered to a nursing woman.

DYSPORT™ (abobotulinumtoxinA) is an acetylcholine release inhibitor and a neuromuscular blocking agent indicated for the temporary improvement in the appearance of moderate to severe glabellar lines associated with procerus and corrugator muscle activity in adult patients < 65 years of age.

The effects of DYSPORT™ and all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults, particularly in those patients who have underlying conditions that would predispose them to these symptoms.

DYSPORT™ is contraindicated in patients with known hypersensitivity to any botulinum toxin preparation or to any of the components in the formulation. This product may contain trace amounts of cow's milk protein. Patients known to be allergic to cow's milk protein should not be treated with DYSPORT™.DYSPORT™ is contraindicated for use in patients with infection at the proposed injection site(s).

There are no adequate and well-controlled studies in pregnant women. DYSPORT™ should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is not known whether DYSPORT™ is excreted in human milk.

I authorize and direct _____ to perform the following procedure of Botox® Cosmetic and Dysport® injections on _____ (patient name) for the treatment of (areas to be treated):

☐ Glabella Initials: _____

☐ Forehead Initials: _____

☐ Crows Feet Initials: _____

☐ Other: _____ Initials: _____

Please initial the following:

_____ The details of the procedure have been explained to me in terms I understand.

_____ Alternative methods and their benefits and disadvantages have been explained to me.

_____ I understand that the FDA has only approved the cosmetic use of Botox® Cosmetic and Dysport® for frown lines between the brows. Any other cosmetic use is considered off label.

_____ I understand and accept the most likely risks and complications of Botox® Cosmetic and Dysport® injections.

Including but not limited to:

- Paralysis of a nearby muscle that could interfere with opening of eye(s).
- Local numbness
- Headache, nausea, or flu-like symptoms
- Swallowing, speech, or respiratory disorders
- Swelling, bruising, or redness at the injection site
- Disorientation and double vision
- Temporary asymmetrical appearance
- Abnormal or lack of facial expression
- Inability to smile when injected in the lower face
- Facial pain
- Product ineffectiveness

_____ I understand and accept that the long-terms effects of repeated use of Botox® Cosmetic and Dysport® injections are unknown. Possible risks and complications that have been identified, but are not limited to:

- Muscle Atrophy
- Nerve irritability
- Production of antibodies with unknown effect to general health

_____ I understand and accept the less common complications, including the remote risk of death or serious disability that exists with this procedure.

ROBERTSON COUNTY
PHYSICAL MEDICINE

_____ I am aware that smoking during the pre and post-operative periods could increase chances of complications.

_____ I have informed the doctor or nurse of all my known allergies, including any allergies to latex.

_____ I have informed the doctor or nurse of all medications I am currently taking including prescriptions, OTC remedies, herbal therapies, and any other.

_____ I have been advised whether I should take any or all of the medications on the days surrounding the procedure.

_____ I am aware and accept that no guarantees regarding the result of this procedure have been made or implied.

_____ I have been informed of what to expect post-treatment, including but not limited to procedures I can do if I wish to maintain the appearance that this procedure provides me.

_____ I am not currently pregnant or nursing, and I understand that should I become pregnant while using Botox® Cosmetic and Dysport® there are risks, including fetal malfunction.

_____ If pre and post-treatment photos and/or video are taken of the treatment for record purposes, I understand that these photos will be the property of the attending doctor or nurse.

_____ The doctor and/ or nurse has answered all my questions regarding this procedure.

_____ I have been advised to seek immediate medical attention if swallowing, speech, or respiratory disorders arise.

_____ I certify that I have read and understand this agreement and that all spaces for initials were filled in PRIOR to my signature.

Patient Signature: _____ Date: _____

_____ I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives of the proposed procedure to the patient. I have answered fully, and I believe that the patient fully understands what I have explained.

Doctor or Nurse Signature: _____ Date: _____

2308 D Memorial Boulevard • Springfield, Tennessee 37172 • Phone (615) 382-8144 • Fax (615) 382-8145

Consent for Use of BOTOX®

BOTOX® is a brand name for botulinum toxin type A, a neurotoxin that blocks muscle contraction by temporarily inactivating the nerves that control them. The effects of BOTOX® become apparent 2-5 days after the injection and generally last 3-4 months. The FDA has approved the use of BOTOX® to treat facial dystonias (spasms), strabismus (crossed eyes) and to soften facial rhytids (wrinkles). There may be alternatives to BOTOX® including medicines or surgery.

Unwanted side effects of BOTOX® include but are not limited to;

- Local bleeding
- 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 the eye, difficulty whistling or drinking from a straw
- Generalized weakness
- Permanent loss of muscle tone with repeated injection
- Flu-like syndrome
- Development of antibodies to BOTOX®
- Infection

BOTOX® contains Human-derived albumin and carries a theoretic risk of virus transmission. There have been no reports of disease transmission through BOTOX®. If you are pregnant, nursing or are allergic to albumin (eggs), you should not receive injections. Patients taking aminoglycoside antibiotics, or with Eaton-Lambert syndrome, Lou Gehrig's disease or myasthenia gravis should not have BOTOX®.

I understand the above and have had the risks, benefits and alternatives explained to me. I give my informed consent for BOTOX® injections today.

_____ _____

Patient Signature Date

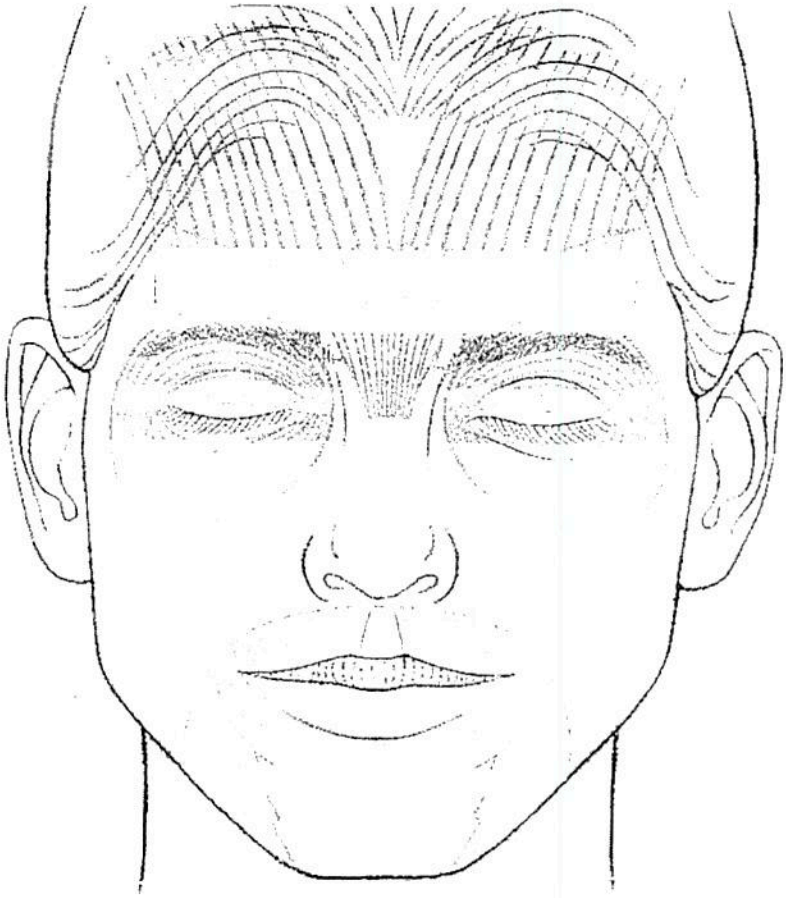
BOTOX® TREATMENT FORM

Patient Name:
Acct # :
Date of Service:

Chief Complaint: _____

_____

_____



Pre Injection Spasm:

LIDS:	OD ___	OS ___
BROWS:	R ___	L ___
FACE:	R ___	L ___
NECK:	R ___	L ___

0 = None
1 = Increased Blink
2 = Tolerable Flutter
3 = Mildly Incapacitating Spasm
4 = Severely Incapacitating Spasm

Injection No. _____
Lot No./ Vial No. _____

Dilution:

1.25 U/0.1ml 2.5 U/0.1ml 5.0 U/0.1ml 10U/0.1ml

Total Units – Lids/ Brow	R_____	L_____
Total Units – Crows feet	R_____	L_____
Total Units – Forehead	_____	
Total Units – Other	_____	_____

TOTAL UNITS _____ TOTAL COST_____

Diagnosis: _____

Plan: _____

_____
Physician's Signature