First name: ______________________ Last name: ______________________________________

Address: ________________________ City: _________________State: _____ Zip code: ________

Best Phone: ______________________ Email: ____

Date of birth: _________ Height: _______ Weight: _______ Profession: _______________________

How did you find us? ☐ Google ☐ Facebook ☐ Instagram ☐ Friend ______________ ☐ Other: __________

MEDICAL HISTORY

Who is your Primary M.D.?_____________________________ Do you see any medical specialists? ☐ Yes ☐ No

If yes, for what?_________________________ Please list all medications you take: __________________

____

____

Any known drug allergies? ☐ Yes ☐ No If yes, please list:__________________________________

Have you ever had a skin allergy? ☐ Yes ☐ No If yes, describe _____________________________________

Do you have a skin allergy to gram-positive bacterial proteins? ☐ Yes ☐ No

Do you have a history of Keloid scarring? ☐ Yes ☐ No Have you had cosmetic injections? ☐ Yes ☐ No

Are you allergic to egg or egg products? ☐ Yes ☐ No Have you a reaction from numbing at the dentist? ☐ Yes ☐ No

Are you using Retin A, Hydroquinone, Glycolic Acid, Accutane, or medication that could cause sun sensitivity? ☐ Yes ☐ No

Have you ever had a cold sore/herpes virus? ☐ Yes ☐ No If so describe?____________

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No Are you breast-feeding? ☐ Yes ☐ No

Do you have a history or diagnosis of Auto Immune Disorder, Numbing of Extremities, Diabetes, Seizure Disorder, cardiac history, or pacemaker implant? ☐ Yes ☐ No If yes, please describe:________________________________

Do you have any freckles, moles or skin condition that have caused concern? If yes, please describe: ______________

Any other health concerns? ____

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the doctor or the nurse of my current medical or health conditions and to update this history with each appointment. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Name: _______________________________

Signature:______________________________ Date: ________________

INFORMED CONSENT

This is an informed consent document, which has been prepared to help inform you about your procedure delivered by injection, the risks associated with this procedure. It is important that you read this information carefully and completely. After reviewing, please sign the consent authorizing the procedure to be performed.

CONTRAINDICATIONS: Injectable procedures are safe for most individuals. There are very few contraindications, however, patients with the following conditions are not candidates: Acute and Chronic Infections, Skin diseases (i.e. SLE, porphyria, allergies), Cancer, Chemotherapy, Severe metabolic and systemic disorders, Abnormal platelet function (blood disorders, i.e. Hemodynamic Instability, Hypofibrinogenemia, Critical Thrombocytopenia), Chronic Liver Pathology, Anti-coagulation therapy, Underlying Sepsis, Systemic use of corticosteroids within two weeks of the procedure, pregnant or breastfeeding.

RISKS & COMPLICATIONS: I have been informed that some of the side effects of injectable therapies include: pain or itching at the injection site, bleeding, bruising, swelling and/or infection, short lasting pinkness/redness (flushing) of the skin, allergic reaction to the solution, injury to a nerve and/or muscle, nausea/vomiting, dizziness or fainting, temporary blood sugar increase

CONSENT: My consent and authorization for this elective procedure is strictly voluntary. By signing this informed consent form, I hereby grant authority to the physician/practitioner to perform procedures/injections to area (s) discussed during our consultation. I have read this informed consent and certify I understand its contents in full. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I agree to adhere to all safety precautions and instructions after the treatment. I have been instructed in and understand post treatment instructions. I understand that medicine is not an exact science and acknowledge that no guarantee has been given or implied by anyone as to the results that may be obtained by this treatment. I also understand this procedure is “elective” and not covered by insurance and that payment is my responsibility. I understand that should I elect to reverse my filler with hyaluronidase that this procedure will be performed at my own expense. Any expenses that may be incurred for medical care I elect to receive outside of this office, such as, but not limited to, dissatisfaction of my treatment outcome will be my sole financial responsibility. Payment in full is due prior to receiving treatment and is non-refundable. I hereby give my voluntary consent to this procedure and release Optimal BioHealth medical staff, and specific technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age and am not under the influence of alcohol or drugs. This consent form shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. I agree, if I should have any questions or concerns regarding my treatment / results I will notify this office at 425-485-1413 immediately so that timely follow-up and intervention can be provided.

Name: ____ Date of Birth:_______________

Signature:______________________________________ Date: ______________________

PRESCRIPTION ANESTHETIC CONSENT

Topical or injectable lidocaine with or without epinephrine may be used to ease the comfort of your treatment. You may be prescribed one or more of the following medications during your visit.

- Lidocaine
- Benzocaine
- Prilocaine
- Phenylephrine
- Epinephrine
- Tetracaine

PLEASE CHECK THOSE THAT APPLY:

☐ I am not pregnant, trying to become pregnant, or lactating

☐ I am not allergic to any of the known substances in any of the prescription anesthetic

I AM AWARE OF THE FOLLOWING POSSIBLE EXPERIENCES/RISKS:

Temporary redness

Temporary rash

Possible lidocaine toxicity with prolonged use, or larger surface areas

Potential allergic reaction

I HEREBY GIVE MY CONSENT AND AUTHORIZATION

I am stating that I fully understand the above prescription anesthetic medication and all risks and benefits have been fully explained to me in detail. I will notify the office immediately of any adverse effects or if any changes occur in my medical history/health.

Signature:____ Date: _______________________

Printed:____

Consent to Use or Disclose Health Information (HIPAA Disclosure)

I authorize **Optimal BioHealth** to use and disclose the health and medical information of for the purposes of Treatment, Payment and Health Care Operations including communication via email, phone, and text message. I understand I may opt-out of individual forms of communication in writing.*

***Treatment** includes activities performed by a health care provider, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

***Health Care Operations** includes the necessary administrative and business functions of our office.

You may review Optimal BioHealth's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Optimal BioHeal has already used or disclosed the information in reliance on this Consent, I understand health care providers generally may not condition treatment on the provision of the authorization.
This consent will auto-renew each year unless otherwise revoked.

SIGNATURE: ______________________________ DATE: ______________

PRINT NAME: ______________________________