

Patient Neuromodulator Intake Form

General Patient Information:

First and Last Name: _____ Birth Date: _____ Age: _____

Address: _____ City: _____ Province: _____

Phone: _____ Email: _____

Occupation: _____ Sex: Male or Female

For Women: Are you currently pregnant, breastfeeding or trying to conceive? Yes or No
(You cannot receive neuromodulator or filler treatments if you are pregnant, breastfeeding or trying to conceive)

Medical History:

Medications you are currently taking or recently stopped taking: _____

Please indicate allergies: Milk Wasp/Bee Other: _____

Medical Conditions and/or Recent Illnesses: _____

Previous injuries or hospitalizations: _____

Family History (cancer, cardiovascular problems, diabetes, psychological problems, etc.): _____

Health Conditions: (do you have a history of the following? Please select all that apply)

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Cold Sore (herpes) | <input type="checkbox"/> Eczema | <input type="checkbox"/> Lupus | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Melasma | <input type="checkbox"/> Keloid (thick) scarring | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hyper/hypo pigmentation | <input type="checkbox"/> Polymyositis | <input type="checkbox"/> ALS or Multiple Sclerosis |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Guillain-Barre Syndrome |
| <input type="checkbox"/> Other auto-immune or neurological disease: _____ | | | |

Areas to address or discuss treatment options:

- | | | |
|---|--|---|
| <input type="checkbox"/> Fine/Deep Lines | <input type="checkbox"/> Tired Looking | <input type="checkbox"/> Teet Grinding (Bruxism) |
| <input type="checkbox"/> Dynamic Wrinkles | <input type="checkbox"/> Chronic Migraines | <input type="checkbox"/> Excessive Sweating (Hyperhidrosis) |

Have you previously had?

- | | | |
|--|--|--|
| <input type="checkbox"/> BOTOX® / Dysport® / Xeomin® | <input type="checkbox"/> Facial Trauma | <input type="checkbox"/> Facial Surgery |
| <input type="checkbox"/> Dermal Fillers | <input type="checkbox"/> Facial Lasers | <input type="checkbox"/> Permanent fillers or implants |

When was the last time you had neuromodulator (i.e. BOTOX®) treatment? _____

Have you ever had a bad reaction to neuromodulators (i.e. BOTOX® / Dysport® / Xeomin®)? Yes or No

Patient Signature

_____ (m/d/y)
Date

Dentist Signature

Photo Release Form

I agree and have consented to have my photos taken. I release and grant permission to the botox course to use my photographs for educational and promotional purposes without compensation. I understand these images may be used for a variety of purposes and may appear on their website, promotional material or other social media.

Patient Name: _____

Patient Signature: _____

Date (M/D/Y): _____

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