

AUBURN NY ORAL SURGERY

Sandeep Singla DDS, MD

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183 Genesee Street

Auburn, NY 13021

Tel: (315) 253-7384

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NEUROTOXIN INJECTION INFORMED CONSENT

Patient's Name

Date of Birth

This form and your discussion with your doctor are intended to help you make informed decisions about your treatment. As a member of the treatment team, you have been informed of your diagnosis, the planned procedure, the risks, benefits, and alternatives associated with the procedure, and any associated costs. Your doctor will be happy to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

Diagnosis: _____

Procedure: _____

Alternative treatments: _____

1. I have been informed of and understand the known risks related to this treatment include but are not limited to:

- Pain, swelling or bruising at the injection site, headache or flu-like symptoms;
- Weakness or loss of facial muscle mobility, possibly affecting appearance and expression;
- Droopy eyelids or uneven eyebrows, crooked smile or drooling;
- No change (i.e. lack of effect) or uneven appearance;
- Eye injury including difficulty closing one or both eyelids tightly, dry eyes, visual problems, ulceration, droopy eyelids or double vision.

2. I have been open and honest with my doctor regarding my motivation for undergoing this procedure, and I realize these cosmetic results cannot guarantee an improved life. Subsequent changes in appearance may occur as a result of smoking, alcohol use, aging, weight loss or gain, sun exposure, pregnancy, menopause, or other circumstances unrelated to the procedure. In addition, the results may not match my expectations and may vary between individuals. Future or additional procedures may be necessary to achieve desired results. I have been informed of and understand that follow up visits or care, additional evaluation, and treatment may be needed.

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3. The safety of Neurotoxin in pregnant women or nursing mothers has not been established. I have advised my doctor if there is a chance I might be pregnant or am lactating.

4. Patient's Responsibilities

I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications (including, but not limited to Aspirin, NSAIDS and Plavix), any allergies, recreational drug use, and pregnancy (if applicable). NOTE: It is important if you have had a stent and are taking Plavix that you inform the surgeon. Stopping Plavix may result in a heart attack, stroke and even death.

I understand and accept that the doctor cannot guarantee the results of the procedure. I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

Patient or Legal Representative Signature

Date

Print Patient or Legal Representative Name/Relationship

Witness Signature

Date

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I

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have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained.

Doctor Signature

Date

Patient's Initials _____