Consent Form: Botulinum Toxin (Botox) Injection for Wrinkles

Injection of Botulinum Toxin (diluted and distilled) in low doses into the facial expression muscles, paralyzes or relaxes these muscles. This treatment is intended to improve the appearance of certain expression wrinkles in the face and is mainly intended for use in the upper part of the face.

In most cases, the improvement is noticeable from within a short time and up to two weeks from the date of injection. The effect of the injected substance vanishes within 3 up to 6 months. Recurrent injections may prolong the effect of the substance for longer periods of time and improve deeper wrinkles. The treatment is performed without anesthesia.

Name of patient: _____ _____ _____ _____

Last Name | First Name | Father's Name | ID. No.

I declare and confirm that I received a detailed verbal explanation from:

Dr. _____ _____

Last Name | First Name

(Hereinafter: The Treating Doctor") regarding the use of Botulinum Toxin (Botox) into the wrinkles in the following sites: _____
(Hereinafter: "the Principal Treatment").

I hereby declare and confirm that I am aware that the treating doctor is a dentist by profession.

I was explained and I understand the alternative treatments that are possible under the circumstances.

I declare and confirm that the side effects of the injections were explained to me, including pain and discomfort in the injection site, local and/or subcutaneous bleeding (hematoma) in the injection site, as well as local infection. These symptoms will subside within a few days.

I was informed of the possibility that as a result of the Botox injection in the forehead, I might suffer from transient weakness and eyelid drooping, double vision or blurred vision which might last for several months. I might also feel ill after the injection, a feeling resembling flu, weakness, headaches and even fever for several days. Very rarely, was it reported on muscular weakness in areas that are distal to the injection site such as swallowing, speech or respiratory disorders, weakness of the limbs, urinary incontinence and cardiac arrhythmia.

The treatment is contraindicated for women who are pregnant or breast feeding or in women who plan to become pregnant within the 6 months preceding the date of treatment.

I hereby give my consent to the Principal Treatment.

_____ _____

Date | Patient's Signature

_____ _____

Name of Guardian (relationship) | Guardian's Signature
(When patient is legally incompetent, a minor or mentally ill)

I confirm that I explained to the patient/the patient's guardian all the aforementioned in the required details and that he/she signed the consent before me, after I was convinced that he/she fully understood my explanation.

_____ _____ _____

Name of Physician | Signature | License No.