

# BOTOX CONSENT FORM

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**Business Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*Informed consent form for Botox and neurotoxin injections. Covers risks, contraindications, expected results, and post-procedure instructions.*

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*\* Required fields*

**Full Name \***

*Jane Doe*

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**Email \***

*jane@email.com*

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**Phone Number \***

*(555) 123-4567*

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**Date of Birth \***

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**Emergency Contact Name \***

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**Emergency Contact Phone \***

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**Treatment area(s) \***

*Options: Forehead Lines / Frown Lines (Glabella) / Crow's Feet / Lip Flip / Bunny Lines / Chin Dimpling / Masseter (Jaw) / Neck Bands / Multiple Areas*

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**Have you had Botox or neurotoxin injections before? \***

*Options: Yes / No*

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**If yes, when was your last treatment?**

*Approximate date*

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**Did you experience any complications from previous treatments?**

**Current medications \***

*Include blood thinners, antibiotics, muscle relaxants...*

**Known allergies \***

*Botulinum toxin, albumin, latex...*

**Are you pregnant or nursing? \***

*Options: Yes / No*

**Do you have any neuromuscular conditions? \***

*Options: Yes / No*

- I understand that results are temporary (3-4 months) and outcomes may vary \*
- I understand the risks including bruising, asymmetry, headache, and rare complications \*
- I consent to before and after photos for my medical records

**Patient Signature \***

*Sign here*

**Date:** \_\_\_\_\_

**CONSENT / WAIVER**

I consent to the injection of botulinum toxin (Botox, Dysport, Xeomin, or equivalent) in the treatment area(s) described above. I understand that: (1) Results typically appear within 3-14 days and last 3-4 months; (2) Risks include bruising, swelling, headache, asymmetry, ptosis (eyelid drooping), and rare allergic reactions; (3) The treatment is contraindicated during pregnancy and nursing, and for patients with neuromuscular disorders; (4) I should avoid lying down for 4 hours post-treatment and avoid strenuous exercise for 24 hours; (5) Touch-up injections may be needed and are not guaranteed to be included. I have disclosed all medications, allergies, and medical conditions. I release the provider from liability for outcomes within the normal range of expected results.

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_