

## **DENTOFACIAL TREATMENT BOTOX® CONSENT FORM**

I, ..... request that..... perform BOTOX® injections into muscles covering my forehead, face, chewing muscles, scalp, neck, or upper back.

### **Indications and alternatives:**

BOTOX® is a brand name for Botulinum toxin type A, a neurotoxin that blocks messages between muscles and the nerves that control them. The temporary effects of BOTOX® become apparent 2-5 days after injection and generally last for 4-6 months. The FDA has approved the use of BOTOX® to treat facial muscle dystonias (spasms), strabismus (crossed eyes), and to temporarily soften facial rhytids (wrinkles) between the eyebrows. While the FDA has not approved injections to treat dental related conditions in other areas of the face, physicians or dentists may perform these “off-label procedures. There are alternatives to BOTOX®, including no treatment, other injectable or ingestible drugs, orthodontics, reshaping teeth or using medicine or surgery of the jawbones, facial nerves or muscles.

I acknowledge that the dentist has explained the following to my satisfaction.

-There is no guaranteed treatment method available for diminishing or “curing” headaches, TMJ or neck/back pain

-BOTOX® treatments have a temporary effect and serial treatments may be required to maintain results, or attain further improvement

-BOTOX® treatments can be costly and probably will not be covered by insurance at this time

-BOTOX® contains human-derived albumin and carries a theoretical risk of virus transmission. There have been no reports of disease transmission through BOTOX®.

I understand that possible side effects and complications to the treated areas and adjacent skin to include redness, swelling, mild pain, bruising, numbness, infection, flu-like symptoms, temporary muscle aching, as well as paralysis of a nearby muscle (which can cause droopy eyelids, droopy mouth, double vision, or neck weakness).

I understand that the following complications can occur and have been reported in the medical literature: permanent numbness, reaction to injection, muscles spasms.

I acknowledge that I am not pregnant, nursing, or have a known allergy to albumin.

I understand that I have not had and should not have Botulinum toxin injections ( Botox, Dysport) at any time within 3 months before or after this course of treatment. This may weaken the effects of the treatment.

I have not been immunized against the effects of Botulinum toxin.

Side effects and complications include but are not limited to:

1. Bruising
2. Undercorrection (not enough effect) or overcorrection (too much effect)
3. Facial asymmetry (one side looks different than the other)
4. Paralysis of a nearby muscle leading to: droopy eyelid, double vision, inability to close eye, difficulty whistling or drinking from a straw.
5. Generalized weakness
6. Permanent loss of muscle tone with repeated injection
7. Flu-like syndrome or respiratory infection
8. Nausea or headache
9. Development of antibodies to BOTOX®
10. BOTOX® contains human-derived albumin and carries a theoretic risk of virus transmission. There have been no reports of disease transmission through BOTOX®.

#### **Contraindications**

**You should not have BOTOX® if you are pregnant, nursing, allergic to albumin, have an infection, skin condition, or muscle weakness at the site of injection, or have Eaton-Lambert syndrome, Lou Gehrig's disease, or myasthenia gravis.**

**I understand the above, and have had the risks, benefits, and alternatives explained to me. No guarantees about results have been made. I give my informed consent for BOTOX® injections today as well as future treatments as needed.**

Patient Signature

Date

Witness Signature

Date