Dermal Filler Form

Dermal Filler Patient History

Name: _____ Date: _____
Address: _____
Telephone: _____ Cell: _____
Date of Birth: _____
Consent signed: Yes No Date: _____
Previous Dermal Filler Yes No Date: _____
Complications: Yes No Date: _____
Type Dermal Fillers: _____
History of Anaphylactic Shock: Yes No Date: _____
History of Allergies: Yes No Date: _____

Medications

Asprin Yes No
Anti-Inflammatories Yes No
Anticoagulants Yes No
Steroids Yes No
Non-Steroidals Yes No
(i.e. Advil, Aleve, Celebrex)

_____
_____
_____
_____

Supplements

Ginko Biloba Yes No
Vitamin A Yes No
Vitamin E Yes No
Garlic Yes No
Flax Oil Yes No

_____
_____
_____
_____

Dermal Filler Patient History (Continued)

Do you have at present, any history of the following medical conditions?

Have you had in the past, any history of the following medical conditions?

1. Multiple Severe Allergies	Yes	No
2. HX of Herpes around the Lips	Yes	No
3. On Immunosuppressive Therapy	Yes	No
4. Autoimmune Disease	Yes	No
5. Medical History	Yes	No

(if answered Yes to any one of the above please explain below)

Comments:

_____
_____
_____
_____
_____
_____
_____
_____

I have answered the above questions to the best of my knowledge

_____ _____

Signature Date

Dermal Filler Form

Dermal Filler Consent Form

Name:

_____

Telephone:

_____

Email Address:

_____

Age: _____ Height: _____ Weight: _____

Address:

_____

Medications:

_____

Allergies: Women: Are you Pregnant or Lactating?:

_____

Physician's Name:

_____

Circle any of the following history you have or have had in the past:

History of Anaphylaxis Multiple Severe Allergies Facial Acne
Hives Immunosuppressive Therapya Autoimmune Disease
Herpes Facial Rashes
Active Inflammatory process Infection (at proposed injection site)
Any Other Medical Disease: _____

EXPLAIN:

Previous Hospitalizations/Operations:

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of the form.

Patient Signature: _____ **Date:** _____

DERMAL FILLER ADMINISTRATION CONSENT

Dermal Filler is a gel of hyaluronic acid generated by streptococcus species of bacteria, chemically cross linked with BDDE, stabilized and suspended in physiologic buffer at PH=7 and concentration of 20 mg/ml. Areas most frequently treated are: nasolabial folds, oral commissures, lips, and Glabellar. Client may experience a slight burning sensation during injections. The procedure takes about 20-30 minutes. Results last approximately six months.

RISKS AND COMPLICATIONS

It has been explained to me hat there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited to: 1) Post treatment discomfort, swelling, redness, and bruising, 2) Post treatment bacterial, viral, and/or fungal infection requiring further treatment, 3) Allergic reaction

PHOTOGRAPHS
I authorize the taking of clinical photographs ant their use for scientific purposes both in publications and presentation. I understand my identity will be protected.

PREGNANCY, ALLERGIES
I am not aware that I am pregnant, have any significant Medical diseases, or have any severe allergies.

PAYMENT
I understand that this procedure is cosmetic and that payment is my responsibility. I hereby voluntarily consent to treatment with Dermal Filler injection for the condition known as: Facial Static Wrinkles. The procedure has been explained to me. I have read the above and understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____