

**PATIENT INFORMATION AND MEDICAL HISTORY**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ E-mail Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

**HISTORY**

**Please check if you have or have had –**

Diabetes _____	Irregular menses _____
Hepatitis _____	Heart problems _____
Herpes _____	Hysterectomy _____
Menopause _____	Hypertension _____
Sensitive to anesthetic _____	Photosensitive Disorder _____
Lupus _____	Autoimmune illness _____

Are you under the care of a physician? \_\_\_\_\_

Current/Recent medications \_\_\_\_\_

**IF YES, EXPLAIN**

Keloid scars	Yes	No	_____
Hives	Yes	No	_____
Skin Cancer	Yes	No	_____
Waxing	Yes	No	_____
Electrolysis	Yes	No	_____
Cold Sores	Yes	No	_____
Hypersensitivity to skin products	Yes	No	_____
Skin Infections	Yes	No	_____
Tanning within the last 6 wks	Yes	No	_____
Use of acne products/drugs	Yes	No	_____
Laser skin resurfacing	Yes	No	_____
Chemical Peels	Yes	No	_____
Photo sensitizing substances	Yes	No	_____
Laser work of any type	Yes	No	_____

Medical Illness \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Allergies of any kind including drugs \_\_\_\_\_

Areas of interest for aesthetic treatment \_\_\_\_\_

Type of treatment requested Botox/ Filler \_\_\_\_\_

**I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## **INFORMED PATIENT CONSENT FOR TREATMENT WITH INJECTABLE FILLERS**

My signature and initials after each statement below constitutes my acknowledgment that:

1. I, \_\_\_\_\_, consent to and authorize \_\_\_\_\_ to perform with injectable fillers to improve the appearance of scars and/or wrinkles, or to have my lips augmented (made larger). The fillers to be used include Hylaform, Restylane, Collagen, and/or Juvederm.  
\_\_\_\_\_
  - The area to be treated \_\_\_\_\_
  - The filler to be used \_\_\_\_\_
  
2. The nature and purpose of the treatment has been explained to me and questions I have regarding the treatment have been answered to my satisfaction. \_\_\_\_\_
  
3. I am fully aware of the risks of complications or injuries that can occur from this treatment, both from know and unknown causes, and I freely assume those risks.  
\_\_\_\_\_

The known complications could include:

- Redness, swelling/edema, itching, pain or pressure lasting more than one week
  - Nodules or induration at the injection site
  - Discoloration of the injection site
  - Poor effect or weak filling
  - Allergic reactions
4. I also certify that I have none of the known conditions that would contraindicate treatment. These conditions include hypertrophy scars, a history of any autoimmune disease, or immune therapy. I am not pregnant, breast-feeding, and I have no known allergy to hyaluronic acid or bovine source collagen. \_\_\_\_\_
  
  5. I certify that I have read this entire informed consent and that I understand and agree to the information stated in this form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the

consent of my parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that any picture taken of my treatment site may be used for publication and teaching purposes, however, my name will not be disclosed and complete confidentiality of my name will be maintained. \_\_\_\_\_

6. No guarantee, warranty or assurance has been made as to the treatment results  
\_\_\_\_\_

7. I understand that the results are of temporary nature, and more treatments will be needed to maintain improvement. I agree to adhere to all safety precautions described here including: \_\_\_\_\_

- Avoiding prolonged sun or UV exposure
- Avoiding saunas for two weeks after injection
- Avoiding steam baths for two weeks after injection
- Make up should be avoided for at least 12 hours after injection

8. I agree to pay \_\_\_\_\_ for the above mentioned services. \_\_\_\_\_

Patient Name (please print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_