Date

Dermal Fillers Consent Form

This consent form is designed to provide the necessary information to decide whether to undergo treatment with dermal fillers.

Dermal filler treatments are used for the treatment of facial creases, wrinkles, folds, contour defects, depression scars, facial lipoatrophy, and/or lip enhancement. The treatments involve multiple small injections of the filler into or below the skin to fill wrinkles and restore volume. The effects of injectable fillers are temporary and no guarantees can be made regarding how long corrections will last in a specific patient. Alternatives to temporary fillers include, but are not limited to, permanent dermal fillers, laser resurfacing, surgical facelift, other laser procedures, or no treatment at all.

Possible risks, side effects, and complications with dermal fillers include but are not limited to redness, swelling, bruising, and infection. Rare complications may include red bumps, pustules, skin discoloration, filler extrusion from skin, visible raised areas of the skin, lumpiness, granulomas, allergic reactions with itchiness, redness, and anaphylactic shock.

Another serious and rare complication of dermal fillers is the risk of unintentionally injecting the filler into a blood vessel or overfilling the tissue which can block blood flow to the treated are or to distant areas causing tissue damage and tissue death (necrosis). Blood vessel occlusion can result in blindness if filler is injected in a blood vessel near the eye such as the tear trough or in the frown area. Blood vessel occlusion can result in necrosis of the side of the nose or cheek if filler is injected into a blood vessel near the nose or the fold between the cheek and the nose.

My signature below certifies that I have fully read this consent form and understand the written information provided to me regarding the proposed procedure. I have been adequately informed about the procedure including the potential benefits, risks, limitations, and alternative treatment options and I have had all of my questions and concerns answered to my satisfaction.

I consent to allow the practitioner in which I am voluntarily seeking services from to consult with and evaluate me in order to determine if I am a good candidate for Dermal Fillers. I understand that photographs will be taken and kept in my file. I agree that these forms have been completed truthfully and to the best of my knowledge and abilities. I understand the contraindications and possible side effects of Dermal Fillers as discussed with the practitioner. Furthermore, I agree to waive all liabilities toward the practitioner for any injury or damages incurred due to my misrepresentation of my health history.

Signature

Date

Date

Botox + Dermal Fillers

Personal Information

Name | DOB | AGE

Address

Phone | Occupation

Email

How did you hear about us?

Primary Physician Name | Phone

Medical History

- ☐ Hepatitis
- ☐ Lupus
- ☐ Autoimmune Disease
- ☐ Cold Sores/Fever Blisters
- ☐ Beef/Dairy Allergy
- ☐ Multiple Sclerosis
- ☐ Eye Disease
- ☐ Keloid Formation
- ☐ Sensitivity/Allergy to Lidocaine
- ☐ Parkinson's Disease
- ☐ Lambert-Eaton Syndrom
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Neurological Disorders
- ☐ Myasthenia Gravis
- ☐ Hypersensitivity to medications
- ☐ Cardiac Disorders
- ☐ Severe Allergy/ Anaphylaxis
- ☐ Porphyria
- ☐ Epilepsy
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Diabetes

Please explain your medical conditions:

_____

_____

List any cosmetic procedures you have had in the past. This includes history of fillers, botox, pdo threading, plastic surgery, or any cosmetic reconstruction.

_____

_____

List any medications including vitamins you are currently taking: _____

_____

List all allergies: _____

Are you pregnant or lactating? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No