Aesthetic Dentistry of Palm City

"Commitment to Excellence"

Welcome

MEDICAL HISTORY
Dermal Fillers

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work/Cell Phone _____

Primary Practitioner's Name & Number _____

_____

B/P _____ T _____ P _____ R _____ DOB _____ Ht _____ Wt _____

Please list all medications you are currently taking: _____

_____

Vitamin Supplements you are on: _____

List any Allergies:. _____

Collagen Tested _____ Date _____ Were there complications? _____

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

Multiple Severe Allergies Hypersensitivity to Medications Lupus Cold Sores

Sensitivity/Allergy to Lidocaine, Sulfa or other _____

Autoimmune Disease (s) _____

OTHER MEDICAL CONDITIONS not listed above that you currently have or have had in past:

_____

Hospitalizations/Operations _____

_____

WOMEN: Pregnant. Trying to get Pregnant, or Lactating (nursing)? _____

Plastic Surgery or other surgery to your face/neck areas & when? _____

Have you had any Dermal Filler procedures before? _____ If yes, what, and were you satisfied with the results? _____

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 history 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 this form.

Patient Signature _____ Date _____

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CONSENT FOR TREATMENT
DERMAL FILLERS

Treatment with Collagen or Hyaluronic Acid Fillers can smooth out folds and wrinkles, add volume to the lips, and contour facial features that have lost their fullness due to aging, sun exposure, illness, etc. Facial rejuvenation can be carried out with minimal complications. Hyaluronic Acids and Collagens are injected into the skin with a very fine needle. The products produce a natural volume under the wrinkle, which is lifted up and smoothed out. The results can often be seen immediately. Treating wrinkles with Hyaluronic Acids and Collagens is fast and safe and leaves no scars or other traces on the face.

RISKS AND COMPLICATIONS

It has been explained to me that 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: I Post treatment discomfort, pain, swelling, redness. bruising, and discoloration. 2) Post treatment infection associated with any transcutaneous injection 3) Allergic Reaction 4) Reactivation of Herpes (cold sores) 5) Lumpiness,
visible yellow or white patches in approximately 20% of cases 6) Granuloma formation 7) Localized Necrosis and/or sloughing, with scab and/or without scab if blood vessel occlusion occurs.

PHOTOGRAPHS

Authorize the taking of clinical photographs and their use for scientific purposes both in publications and presentations. I understand my identity will be protected.

PREGNANCY, ALLERGIES & DISEASE

I am not aware that I am pregnant. I am not trying to get pregnant. I am not Lactating (nursing. I do not have or have not had any major illnesses which would prohibit me from receiving Collagen or Hyaluronic
Acid. If am receiving Zyderm/Zyplast® or Cosmoderm/CosmapiastrM I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to Lidocaine.

IF RECEIVING COLLAGEN

I have read The brochure titled 7yderm®/Zyplos or CosmopiastTM/CosmodermTMCollogen Explained" in it's entirety and have discussed the risks and benefits of injectable collagen treatment with my physician and/or his/her representative and have hod aft my questions answered. / I understand the information provided. Initials_____

PAYMENT

I understand that this procedure is elective and cosmetic and that payment is my responsibility.

RESULTS

I am aware that full correction is important and that follow-up touch ups/treatments will be needed to maintain the full effects. I am aware that the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue condition, my general health and life style conditions, and sun exposure. The correction, depending on these factors may last 3-6 months and in sonic cases longer. I have been instructed in and understand post treatment instructions and have been given a copy of them.

I hereby voluntarily consent to treatment. The procedure(s) 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. I certify that if I have any changes occur in my medical history I will notify the office.

Patient Name (print) Signature Date

Witness Name (print) Signature Date

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CONSENT TO RECEIVE HYALURONIC ACID® INJECTION

A. PURPOSE AND BACKGROUND

As my patient, you have requested my administration of a Hyaluronic Acid (Hyaluronic Acid, Perlane, Juvederm Ultra, Juvederm Ultra Plus, Preveuej; which are stabilized hyaluronic acids used in the correction of moderate to severe facial wrinkles and folds. All medical and cosmetic procedures carry risks and may cause complications. The purpose of this document is to make you aware of the nature of the procedure and its risks in advance so that you can decide whether or not to go forward with the procedure

B. PROCEDURE

1. This product is administered via a syringe, or injection, into the areas of the face sought to be filled with the hyaluronic acid to eliminate or reduce the wrinkles and folds.
2. An anesthetic either topical numbing medicine or a dental block (intraoral injections) may be used to reduce the discomfort of the injections.
3. The treatment site(s) is washed first with and antiseptic (cleansing) solution.
4. Hyaluronic Acid is a clear transparent gel that is injected under your skin into the tissue of your face using a thin gauge (usually 30 C) needle.
5. The depth of the injection(s) will depend an the depth of the wrinkle(s) and its location(s)
6. Multiple injections might be made depending on the site, depth of the wrinkle, and technique used.
7. Following each injection, the injector should gently massage the correction site to conform to the contour of the surrounding tissues.
8. If the treated area is swollen directly after the injection, ice may be applied on the site for a short period.
9. After the first treatment, additional treatments of Hyaluronic Acid may be necessary to achieve the desired level of correction.
10. Periodic touch-up injections help sustain the desired level of correction.

C. RISKS/DISCOMFORT

1. Although a very thin needle is used, common injection-related reactions could occur, These could include: some initial swelling, pain, itching, discoloration, bruising or tenderness at the injection site, You could experience increased bruising or bleeding at the injection site if you are using substances that reduce blood clotting such as aspirin or other non steroidal anti—inflammatory drugs such as Advil® or vitamins such as Vit E.

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2. These reactions generally lessen or disappear within a few days but may last for a week or longer.

3. As with all injections, this procedure carries the risk of infection. The syringe is sterile and standard precautions associated with injectable materials have been taken.
4. Same visible lumps may occur temporarily following the injection.
5. Some patients may experience additional swelling or tenderness at the injection site and in rare occasions, pustules might form. These reactions might last for as long as approximately 2 weeks, and in appropriate cases may need to be treated with oral corticosteroids or other therapy.
6. Hyaluronic Acid should not he used in patients who have experienced this hypersensitivity, those with severe allergies, and should not be used in areas with active inflammation or infections (e.g.. Cysts Rashes or hives).
7. Hyaluronic Acid should not be used in areas other than the tissues of the face. (Hyaluronic Acid is now being used in the hands).
8. If you are considering laser treatment, chemical skin peeling or any other procedure based on a skin response after (one week after) Hyaluronic Acid treatment, or you have recently had such treatments and the skin has not healed completely, there is a possible risk of an inflammatory reaction at the implant site.
9. Most patients are pleased 'with the results of Hyaluronic Acid use. However, like any cosmetic pro cedure, there is no guarantee that you will be completely satisfied. There is no guarantee that wrin kles and folds will disappear completely, or that you will not require additional treatment to achieve the results you seek, While the effects of Hyaluronic Acid use can last longer than other comparable treatments, the procedure is still temporary. Additional treatments will be required periodically, gen erally within 4-6 months to one year. Involving additional injections for the effect to continue.
10. After treatment, you should minimize exposure of the treated area to excessive sun or UV lamp exposure and extreme cold weather until any initial swelling or redness has gone away.

D, BENEFITS

Hyaluronic Acid has been shown to be safe and effective when compared to collagen skin implants and related products to fill in wrinkles, lines and folds in skin on the face. Its effect, once the optimal location and pattern of cosmetic use is established, can last 6 months or longer without the need for re administration .

E. ALTERNATIVES

This is strictly a voluntary cosmetic procedure. No treatment is necessary or required.

Other alternative treatments which vary in sensitivity, effect and duration include:

F. COST/PAYMENT

The cost of treatment will be billed to you individually. Since most uses of Hyaluronic Acid are considered cosmetic, they are generally not reimbursable by government or private health care insurers.

G. QUESTIONS

This procedure has been explained to you by your physician/practitioner, or the person who signed below and your questions were answered. If you have any other questions about this product or procedure, you many call _____ At( ) ____ _____ his/her associate at ( ) _____-_____

H. CONSENT

You have been given a copy of this consent form. Your consent and authorization for this procedure is strictly voluntary. By signing this informed consent form, you hereby grant authority to your physician/practitioner to perform Facial Augmentation and Filler Therapy/Injections using Hyaluronic Acid and/or to administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of your condition. The nature and purpose of this procedure, with possible alternative methods of treatment as well as complications, have been fully explained to your satisfaction. No guarantee has been given by anyone as to the results that may be obtained by this treatment. have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information from my physician/practitioner and feel that I am sufficiently advised to consent to this procedure. I hereby give my consent to this procedure and have been asked to sign this form after my discussion with the physician/practitioner.

Patient Name (print)_____ Signature_____Date_____

Practitioner Name (print)_____ Signature_____ Date_____

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