DERMAL FILLERS CONSENT FORM

Finesse Aesthetics

Subtle Solutions for Smoother Skin

PATIENT PERSONAL AND CONTACT DETAILS

Name: _____

Address: _____

Phone: _____

Email: _____

D.O.B _____

MEDICAL HISTORY

- Is there any chance you could be pregnant? _____ Yes/No
- Are you breastfeeding? _____ Yes/No
- Are you taking any medication including "over the counter" medication and/or supplements?
  If yes – please detail?
  _____ Yes/No
- Have you taken aspirin, warfarin or ibuprofen in the last week? _____ Yes/No
- Are you undergoing any dental treatment? _____ Yes/No
- Do you have any allergies? If yes - please detail _____ Yes/No
- Have you ever had an anaphylactic reaction? If yes – please detail _____ Yes/No
- Have you had any procedures in your facial area? (e.g. laser treatment, skin peels, IPL skin resurfacing, plastic surgery, Injury, metal stents)
  If yes – please detail_____ Yes/No
- Have you taken Roaccutane for acne in the past 12 months? _____ Yes/No
- Do you suffer from keloid scarring? _____ Yes/N0
- Do you suffer from herpes (cold sores)? _____ Yes/No
- Have you previously had filler treatments? If yes – when? _____ Yes/No
- Do you suffer with skin infections/problems? (eg. Pigment disorders, increased light sensitivity, open wounds or lesions) If yes – please detail _____ Yes/No
- Do you have a history of HIV, hepatitis, rheumatoid arthritis or other auto-immune disease?
  If yes – please detail_____ Yes/No
- Do you have any medical condition?
  If yes – please detail_____ Yes/No

I confirm that I have answered to the best of my ability

Name:

Signature:

Date:

INFORMED CONSENT – DERMAL FILLERS

- I confirm that I consent to receiving treatment using hyaluronic acid filler.
- I have been given sufficient information to enable me to understand the use of the product.
- Some redness, swelling, haematomas or bruising may occur following treatment. These will usually resolve within a few days.
- As with all injectable treatments, there is a minimal risk of infection, vessel occlusion, granuloma, abscess formation and hypersensitive reaction.
- I agree to the use of a topical anaesthetic cream.
- I agree to follow the post-treatment advice given to me by my practitioner.
- I understand that the practice of medicine and surgery is not an exact science and therefore that no guarantee can be given as to the results of the treatment referred to in this document.
- I accept and understand that the goal of this treatment is improvement, not perfection, and that there is no guarantee that the anticipated results will be achieved.

Consent to the treatment detailed in this form:

Name:

Signature:

Date:

TREATMENT RECORD

Date:

Areas Treated:

Product Type:

Lot Number:

Expiry Date:

Notes