Aesthetic and Anti Aging Medical Center

100 S.Military Trail,Suite 10 Deerfield Beach,FL33442
tel:954 426 9600   fax: 954 426 2257
www.aaamc.net

CONSENT FOR TREATMENT

DERMAL FILLERS

Treatment with Dermal 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. Dermal fillers 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 Dermal Fillers 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 : 1) Post treatment discomfort, swelling, redness, and bruising, discoloration 2) Post treatment infection associated with any transcutaneous injection 3) Allergic reaction (Collagen), 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
I 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 Restylane. If I am receiving Zyderm/Zyplast® or Cosmoderm/Cosmoplast™ I certify that I do not have multiple allergies or high sensitivity to medications, including but not limited to Lidocaine.

PAYMENT
I understand that this procedure is 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 some cases longer. I been instructed in and understand post treatment instructions and have been given a copy of them.

I hereby voluntarily consent to this elective 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.

X______________________________ Patient Signature Date

X______________________________ Witness Signature Date

______________________________ Patient Name Date

______________________________ Witness Name Date

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PRE-TREATMENT INSTRUCTIONS

Dermal Fillers

A few simple guidelines before your treatment can make a difference between a good result and a fantastic one.

If you have a history of Herpes (cold sores) you must be treated 2 days prior and 8 days after treatment with Valtrex 500mg BID (twice a day) or Zovirax 400mg TID (three times a day).

If you develop a cold sore, blemish, or rash, etc. prior to your appointment you must reschedule.

If you have a special event or vacation coming up schedule your treatment at least 2 weeks in advance.

NO Aspirin, Motrin, Gingko Biloba, Garlic, Flax Oil, Cod Liver Oil, Vitamin A, Vitamin E, or any other essential fatty acids at least 3 days to 1 week before and after treatment.

Discontinue Retin-A two (2) days before and two (2) days after treatment.

AVOID: Alcohol, caffeine, Niacin supplement, high-sodium foods, high sugar foods, refined carbohydrates (you may eat fruit), spicy foods, and cigarettes 24-48 hours before and after your treatment

Patient Name: ______________________________**Patient Signature:** _______________________**Date:**_____________

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POST TREATMENT INSTRUCTIONS

Dermal Fillers

A few simple guidelines both pre and post-treatment can make a difference between a good result and a fantastic one.

Do NOT, touch, press, rub, or manipulate the implanted areas for 6 hours after treatment. You can cause irritation, sores, and/or problems, and possible scarring if you do.

AVOID Aspirin, Motrin, Gingko Biloba, Garlic, Flax Oil, Cod Liver Oil, Vitamin A, Vitamin E, or any other essential fatty acids at least 3 days after treatment.

AVOID: Alcohol, caffeine, Niacin supplement, high-sodium foods, high sugar foods, refined carbohydrates (you may eat fruit), spicy foods, and cigarettes 24-48 hours after your treatment

Avoid Vigorous Exercise and Sun and Heat exposure for 3 days after treatment.

Discontinue Retin-A two (2) days after treatment. It is best to wear no makeup or lipstick until the next day. Earlier use can cause pustules.

One side may heal faster than other side.

You must wait 2 weeks before retreating or correction.

******Please report any redness, blisters, or itching immediately if it occurs after treatment.******
I certify that I have been counseled in post treatment instructions and have been given written instructions as well.

Patient Name: ______________________________ **Patient Signature:** ________________________ **Date:** _____________

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PATIENT INFORMATION SHEET

Date:____________________

Last Name: ____________________ First Name ________________________________

Date of Birth: __________________ Social Security Number ________________________

Adress____Apt#________________

City: ___________________State ______ Zip_________________

Phone Numbers Home_______________ Cell _______________Work______________

Occupation_______________________email address________________________________

How did you hear of our services?____

Reason for Consult____

____

Please Complete the Following Medical Questions

Are you seeking treatment for Cosmetic _______or medical purposes?__________________

Prior surgeries and dates:____

Have you ever had cosmetic enhancement including Botox, Dysport, soft tissue filler, Vein tx, Laser, Photo rejuvenation treatments for any reason? Yes___ No___# times per yr___

Dates & Type of Tx.____

Have you had any side effects or complications from Botox,Dysport or Skin fillers? No__Yes__

If yes explain:____

Do you, or have you ever had a major Illness?_____________________________________

Do you have any acute or chronic skin disease?_____________________________________

Do you have a history of cold sores or have you any now?_____________________________

Have you ever experienced any muscle weakness?___________________________________

Are you currently being treated for any physical or mental condition? No____Yes___Pease Explain____

Are you taking any prescribed medications? No__Yes___List:_____________________________

____

Allergies____Reactions________________________

Do you smoke? No____Yes____per day x____years x____ Quit____When?________

Do you drink alcohol? Yes___No___Amount_____Do you use illeagal drugs?Yes___No___

Please list below all prescribed, herbal,or over the counter medications you are presently taking, or have taken within the past 2 weeks:____

____

Patient Signature: X_________________________ **Date:**_________________________

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Skin Type Assessment

Patient Name: ____________________________ **Date:** ______________________

Genetic Disposition:

Score	0	1	2	3	4
Eye Color	light blue, green	gray	blue	dark brown	Brown/black
Hair Color	sandy, red	blonde	chesnut/dark blonde	dark brown	black
Skin Color	Reddish	Very pale	Pale	Light brown	Dark brown
Freckles	Many	Several	Few	Incidental	None

Reaction to Sun Exposure:

Score	0	1	2	3	4
Sunburn	Redness/blistering/pees	Blistering/peels	Sometimes peels	Rarely burns	never
Turn Brown	Hardly/not at all	Light tan	Medium tan	Tans easily	Browns quickly
Brown after sun	Never	Seldom	Sometimes	Often	Always
Face reaction	Very sensitive	Sensitive	Normal	very resistant	No problem

Tanning Habits:

Score	0	1	2	3	4
When last exposed	>3 months	2-3 months	1-2 months	< 1 month	< 2 weeks
Treatment Area	Never	Hardly ever	Sometimes	Often	Always

Total: _____________

Heritage:

For each parent of African American or East Indian descent add	10
For each grandparent of African-American or east Indian add (if no points for parents)	5
If Asian, Hispanic, East Indian, Mediterranean, Pacific Islander or indigenous to the Americas add	5
For each great –grandparent of African-American descent add (if no points from parents and grandparents)	3

For Office Use only

Summary:

Total for genetic disposition + reaction to sun + Tanning ______
Total for Heritage ______
Skin Type Score (add above 2 lines) **Total** ______

Skin Type Score	Skin Type
0 to 8	**I**
9 to 16	**II**
17 to 24	**III**
25 to 30	**IV**
31 to 34	**V**
35 and over	**VI**