PATIENT MEDICAL HISTORY/CONSENT FORM: DERMAL FILLERS

Name: ____ Date: __________________

Address: ____

City: ____ State: _______________ Zip: ___________

Email: ____

Telephone (Home): ___________________________ (Work/Cell): ___________________________

Primary Physician's Name/Number: ____

B/P:___________ T:________ P:_____ R:_____ DOB:_________ Age:_____ Ht:_____ Wt:_____

Are you part of the Brilliant Distinctions Program? (Please Circle) Yes No

Please list all medications you are currently taking: ____________________________________
____

List vitamin supplements you are taking: ____
____

List any allergies you may have: ____
____

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 Sensitivity/Allergy to Lidocaine (collagen)
Autoimmune Disease History of Cold Sores Allergy to Beef (collagen) Lupus

List any OTHER MEDICAL CONDITIONS (not listed above) that you currently have or have had
in the past: ____

Previous Hospitalizations/Operations: ____
____

Are you pregnant, trying to get pregnant, or lactating (nursing)? _________________

Have you had 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: ____________________

CONSENT FOR TREATMENT

DERMAL FILLERS

Treatment with Collagen or Restylane 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. Restylane and Collagen 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 Restylane or Collagen is fast, 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 or 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 and 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.

If Receiving Collagen: *I have read the brochure titled "Zyderm®/Zyplast® or Cosmoplast™/ Cosmoderm™ Collagen Explained" in its entirety and have discussed the risks and benefits of an injectable Collagen treatment with my physician and/or his/her representative and have had all my questions answered. I understand the information provided.*
*Initials*______________

Payment

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

Leftover Product

You may opt to save a partial syringe to use after the initial swelling goes away, but it will be discarded if not used within three weeks. *Initials*_______________

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 upon many factors including, but not limited to, age, sex, tissue condition, my general health and lifestyle conditions, and sun exposure. The correction, depending upon these factors, may last 3-6 months and in some 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 occurring in my medical history, I will notify the office.

Patient Signature: _______________________________________ Date: __________________

Witness Signature: _______________________________________ Date: __________________

PRE-TREATMENT INSTRUCTIONS

DERMAL FILLERS

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

If you are to be receiving Zyplast®/Zyderm®, you must be tested an absolute minimum of 1 month before. You must get retested if 1 or more years have gone by since your last Collagen treatment.

If you have been tested for Collagen at another office you MUST show proof of a collagen test within 1 year of the testing.

If you have a history of Herpes (cold sores) you must be treated 2 days prior and 8 days after Collagen/Restylane treatment with Valtrex 500mg BID (2 times a day) or Zovirax 400mg TID (3 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 three days to one week before and after treatment.

Discontinue Retin-A 3 days before and 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 before and after your treatment.

If you opt to save a partial syringe, we can save it here at the office for up to three weeks. After that it will be thrown out. There is a $35.00 appointment fee to inject the remainder of the syringe.
Initials ________

PATIENT INFORMATION

Patient Name: ________________________________ Date: __________________________________

History of recent NSAID Yes □ No □ Recent ASA Y□ N□ Pregnant Yes □ No □ Patient Initials _______

Significant Medical History____

Current Medical History ____

TREATMENT HISTORY

Patient's first filler treatment: Yes □ No □

Patient's first BTX treatment: Yes □ No □

Previous filler problems? _____________________

Previous BTX problems? ________________

____

____

Date of last filler treatment ____________________
Off-label consent given _______________________
Informed consent given ______________________

Date of last BTX treatment _______________
Off-label consent given __________________
Informed consent given _________________

PATIENT ANALYSIS AND OPERATIVE REPORT

Patient Name: ____ Date: ____________________________

Current Treatment

Treated Feature	Product and Amount	Clinical Analyses/Comments
Frontails (Horizontal Rhytids)		
Brows Asymmetry		Right Lower? Left Lower?
Glabellar Complex (Frown Lines)		
Aperture Width		Right Lower? Left Lower?
Crows Feet		
Nasalis (Bunny)		
Malar		
Nasolabial Folds		
Marionette Lines		
Vertical Lip Lines (Orbicularis Oris)		
Vermillion Border		
Lip		
Oral Commisures (Mouth Corners)		
Chin		
Platysma Bands		
Necklace Lines		

Product Information

Product Name	Product Lot Number/Label	Product Expiration Date
1)		
2)		
3)		

Post Treatment Information

Complications	
Instructions Given	
Follow-Up Appointment	
Comments	

Nurse Signature: ____

POST-TREATMENT INSTRUCTIONS

DERMAL FILLERS

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

AVOID Aspirin, Motrin, Gingko Biloba, Garlic, Flax Oil, Code Liver Oil, Vitamin A, Vitamin E, or any other essential fatty acids at least 3 days to 1 week before and after Collagen treatment.

Discontinue Retin-A 3 days before and 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 before and after your treatment.

AVOID vigorous exercise and sun and heat exposure for 3 days after treatment.

Apply No makeup or lipstick until the next day; earlier use can cause pustules.

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.

One side may heal faster than the other side.

You must wait 2 weeks before re-treating or correcting.

Please report any redness, blisters, or itching immediately if they occur after collagen treatment.

I certify that I have been counseled in post-treatment instructions and have been given written instructions as well.

Patient Signature: ____ Date: ______________________

Senza Pelo Med Spa

Policies Concerning Late and Cancelled Appointments and Returned Checks

- **Please notify Arizona Laser, Electrolysis & Skin Care within the time frames listed below when cancelling or changing an appointment:**

    - **24 hours notice for appointments one hour or less.**
    - **72 hours notice for appointments more than one hour.**
    - **Any treatment 4 hours or more require a 96-hour notice.**

  Adequate notification will allow for any openings to be filled.

- **A fee of $10.00 per half hour will be charged for late cancellations or "no shows" for electrolysis and skin care treatments.** ***A $35.00 charge will be required for late cancellations or "no shows" for laser treatments and treatments with our Nurse.***

- **Being late for an appointment will be included in the treatment time.**

- **Three "no shows" will require prepayment of the treatment.**

- **There will be a $25.00 service charge for returned checks.**

- **All Saturday appointments are prepay only for scheduled time.**

- **We do offer e-mail and text message appointment reminders that are sent out two days prior to your appointment. Occasionally, we have technical difficulties with our system so you are still responsible for your appointment whether or not you receive your reminder.**

Patient Signature: ___________________________________

Technician Signature: ________________________________