KESPRA MEDICAL CENTER

22 Meridian Rd, Suite 10 Edison, NJ 08820

Dermal Filler Consent Form

Name:

____

Telephone:

____

Email Address:

____

Age: ______________ Height: ______________ Weight: ______________

Address:

____

Medications:

____

Allergies: Women: Are you Pregnant or Lactating?:

____

Physician's Name:

____

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

History of Anaphylaxis   Multiple Severe Allergies   Facial Acne
Hives   Immunosuppressive Therapya   Autoimmune Disease
Herpes   Facial Rashes
Active Inflammatory process Infection (at proposed injection site)
Any Other Medical Disease: ______________________

EXPLAIN:

Previous Hospitalizations/Operations:

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 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 the form.

Patient Signature: ______________________________ **Date:** ______________

DERMAL FILLER ADMINISTRATION CONSENT

Dermal Filler is a gel of hyaluronic acid generated by streptococcus species of bacteria, chemically cross linked with BDDE, stabilized and suspended in physiologic buffer at PH=7 and concentration of 20 mg/ml. Areas most frequently treated are: nasolabial folds, oral commissures, lips, and Glabellar. Client may experience a slight burning sensation during injections. The procedure takes about 20-30 minutes. Results last approximately six months.

RISKS AND COMPLICATIONS

It has been explained to me hat 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, 2) Post treatment bacterial, viral, and/or fungal infection requiring further treatment, 3) Allergic reaction

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PHOTOGRAPHS

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

PREGNANCY, ALLERGIES

I am not aware that I am pregnant, have any significant Medical diseases, or have any severe allergies.

PAYMENT

I understand that this procedure is cosmetic and that payment is my responsibility. I hereby voluntarily consent to treatment with Dermal Filler injection for the condition known as: Facial Static Wrinkles. The procedure 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.

Patient Signature: ______________________________ **Date:** _____________

Witness Signature: ______________________________ **Date:** _____________