



DERMAL FILLER CONSENT FORM

All the dermal fillers used in our practice are made of substances naturally found in your body. Over time, these will be broken down naturally by your body. Although the most frequently treated areas are nasolabial folds, oral commissures, and lips, the area around the cheekbones may be injected to give the face a younger, fuller and more natural appearance. You may experience discomfort during injection. Anesthetic is used on the skin and is mixed with the filler to minimize this discomfort. The procedure takes about 30-60 minutes.

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, 2) Post treatment bacterial, viral, and/or fungal infection requiring further treatment, 3) Allergic reaction

The most common symptoms include temporary injection site reactions such as swelling, pain/tenderness, redness, and lumps/bumps which are normal. These reactions are typically mild and go away within 3 days. Consistent icing of these areas in the first 12 hours substantially reduces these symptoms. Some patients may experience one or more of these symptoms for a longer period of time; however, these symptoms typically go away without treatment. Patients using aspirin, ibuprofen, and other non-steroidal anti-inflammatory drugs, or warfarin (a blood thinner) prior to treatment with may notice increased bruising or bleeding at or near the injection sites.

MEDICAL CONDITIONS

I am not aware that I am pregnant, have any significant medical conditions or severe allergies. I understand that my ENTIRE medical history is essential to determine whether I should receive this treatment and to the best of my knowledge have shared this history. I will not hold any staff member responsible for any errors or omissions that I have made.

A local anesthetic such as Lidocaine is typically used on the skin as well as being mixed with the filler to provide minimize discomfort at the injection site. Please tell your doctor if you have had any previous reactions to anesthetics.

PHOTOGRAPHS

I authorize the taking of clinical photographs for my medical record only. These photos may not be used for any other purpose without my written permission.

CONSENT

I hereby voluntarily consent to treatment with Dermal Filler injection. The procedure has been explained to me. I have read the above and my questions have been answered satisfactorily. I accept the risks and complications of the procedure.

Client Signature

Date

Printed Client Name

Witness Signature

Date

Printed Witness Name

Please contact our office at 951-444-1362 with any questions or concerns.

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