Dermal Filler Intake Form

Name _____ Birthday _____

Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Phone #_____ Email: _____

Emergency Contact Name & Number: _____

Would you like to be added to our email list for information and discounts? ☐ Yes ☐ No

How did you hear about us?_____

What (specifically) are you hoping to get out of today's session?_____

_____

Medical and Cosmetic History

Do you have any allergies? ☐ Yes ☐ No
If yes, please list: _____

Are you currently taking any prescription or over-the-counter medications, or vitamins? This includes oral medications as well as injectibles or topicals. ☐ Yes ☐ No
If yes, please list: _____

Have you had any cosmetic procedures, such as dermal fillers, fillers, reconstruction, or plastic surgery? ☐ Yes ☐ No
If yes, please list: _____

Have you seen a dermatologist for anything in the past year? ☐ Yes ☐ No
If yes, please explain: _____

Are you pregnant or nursing? ☐ Y ☐ N

Do you have epilepsy or other neurological disorders? ☐ Y ☐ N

Do you have diabetes? ☐ Y ☐ N

Do you have any cardiovascular conditions? ☐ Y ☐ N

Do you have high blood pressure? ☐ Y ☐ N

Do you have low blood pressure? ☐ Y ☐ N

Are you on blood-thinning medication? (prescription or non-prescription) ☐ Y ☐ N

Do you have any skin diseases or conditions? ☐ Y ☐ N

Do you have an autoimmune disease or disorder? ☐ Y ☐ N

Do you have any infectious diseases? ☐ Y ☐ N

Have you ever had hepatitis? ☐ Y ☐ N

Do you have herpes or cold sores (active or inactive)? ☐ Y ☐ N

Do you have an eye disease? ☐ Y ☐ N

Do you have amyotrophic lateral sclerosis? ☐ Y ☐ N

Do you have lupus? ☐ Y ☐ N

Dermal Filler Intake Form (cont)

Do you have Lambert-Eaton Myasthenic Syndrome?	Y	N	Do you have myasthenia gravis?	Y	N
Do you have Parkinson's?	Y	N	Do you have multiple sclerosis?	Y	N
Do you have or have you ever been diagnosed with cancer, Melanoma, or a tumor?	Y	N	Do you have porphyria?	Y	N
			Do you bruise easily?	Y	N
If yes, are you undergoing any kind of treatment?	Y	N	Do you experience keloid scarring?	Y	N
Do you have a sensitivity to lidocaine?	Y	N	Are you hypersensitive to medications?	Y	N
Do you experience anaphylaxis?	Y	N	Do you use an inhaler or angina medication?	Y	N
Are you currently ill or feverish?	Y	N			

Please list any other conditions, diseases, or disorders:_____

_____

The following conditions are contraindications and may prevent treatment at this time:

- Pregnant or nursing
- Current infections
- Hypersensitivity or allergy to filler
- Allergy or sensitivity to lidocaine

Is there any additional information you would like to let your provider know? _____

_____

With my signature below, I confirm that I have accurately completed the above information to the best of my knowledge. I agree to notify the provider of any other relevant information that may affect my procedure, including any changes to the information above. I agree to communicate with my provider about any pain or discomfort experienced during or after the procedure. I release my prover (name written below) of any and all liability of injury or damages that may arise because I have not represented my medical history accurately.

Printed Client's Name	Signature	Date
_____	_____	_____
Provider's Name	**Signature**	**Date**
_____	_____	_____

Dermal Filler Consent

__ I have elected, by my own decision, to have dermal fillers administered.

__ I acknowledge that not all dermal fillers are FDA approved, and fillers may be used for "on-label" and "off-label" purposes.

__ The treatment, including the process and objective, has been explained to me before undergoing dermal filler treatment.

__ I have been given the opportunity to ask questions regarding any benefits, risks, or possible complications of the procedure.

__ I understand that my provider has taken measures to minimize any risks or negative reactions. Although it is impossible to list every possible risk or reaction, I acknowledge any reaction or complications associated with the procedure as they have been explained to me.

__ I understand the treatment may be uncomfortable at times and I may experience unusual sensations like pin-pricks, or I may experience tightness or heat.

__ I have followed all pre-procedure care instructions as they have been explained to me.

__ I understand all aftercare procedures for dermal fillers as they have been explained, and I intend to adhere to the instructions given to me.

__ I understand that dermal fillers used to treat wrinkles, lines, scars, folds, lips, and facial volume are not permanent and will need to be administered again for continued results.

__ I understand that it is possible to experience temporary uneven results as the treatments integrate into the tissue.

__ I understand that I may experience adverse reaction at the injection site including but not limited to swelling, stinging, or lumpy feeling under the skin that should resolve.

__ I understand I should avoid the use of Retin-A type products.

__ I understand that results may depend on the type of filler used and the volume of the filler.

__ I understand that there are no guaranteed results and that my results may vary from others. I may require further treatments at an additional cost to achieve my desired results.

__ I understand that the use of anticoagulants or NSAID's (including herbal supplements) may increase the risk of bruising or bleeding post-treatment.

__ I understand that dermal fillers are not recommended if I have any of the contraindications listed on the intake form and should provide my full and accurate medical history.

__ I confirm that I have given an accurate account of my medical history, including any allergies or medications that I am currently taking or intend to take.

With my signature below, I confirm that I have read fully and understand the information in this consent form and all details included. I have provided an accurate account of my medical history including any medications I take or intend to take, and any medical procedures I intend to undergo. By signing below, I agree to accept all and full responsibility for any risks, injuries, damages, or side effects that may occur as part of the procedure. I will not hold my dermal filler provider (recorded below) responsible for any conditions present, but not disclosed at the time of treatment, that may affect the treatment.

Printed Client's Name	Signature	Date
_____	_____	_____
Provider's Name	Signature	Date
_____	_____	_____

Dermal Filler

AFTERCARE

- AFTER GETTING DERMAL FILLERS REDNESS, SWELLING, BRUISING, AND TENDERNESS AROUND THE INJECTION SITE ARE COMMON REACTIONS. THESE SYMPTOMS USUALLY SUBSIDE AFTER A FEW DAYS BUT CAN LAST UP TO A WEEK.
- AVOID TOUCHING OR RUBBING THE AREA FOR AT LEAST 6 HOURS.
- AVOID ALCOHOL FOR 24 HOURS.
- AVOID STRENUOUS EXERCISE AND HEAT EXPOSURE INCLUDING SAUNAS AND HOT TUBS FOR 48 HOURS.
- DO NOT HAVE ANY OTHER TREATMENTS ON THE FACE OR MOUTH FOR AT LEAST 2 WEEKS.
- AVOID ASPRIN AND OTHER NON-STEROIDAL ANTI-INFLAMMATORY DRUGS FOR 5 DAYS.
- USE A COLD COMPRESS AND TYLENOL EVERY 4-6 HOURS TO REDUCE SWELLING, SORENESS, AND DISCOMFORT.
- AVOID DIRECT SUNLIGHT AND ALWAYS WEAR SPF 30+.
- USE A GENTLE CLEANSER AND ANTISEPTIC CREAM AS SUGGEST BY YOUR PROVIDER.