Aesthetic SOLUTIONS NY

Aleksandr Benji FNP
98-71 Queens Blvd, Rego Park NY 11374
646-301-4000

Name: _____ Date of Birth _____

Dermal Filler History/Consent Form

(Please print)

Women: Are you Pregnant or Lactating? _____

Topical Anesthetic Allergy: _____ Specify _____

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

- ✔ History of Anaphylaxis
- ✔ Multiple Severe Allergies
- ✔ Facial Acne Facial Acne
- ✔ Hives
- ✔ Immunosuppressive therapy
- ✔ Autoimmune Disease
- ✔ Herpes/ around lips
- ✔ Facial Rashes

Active Inflammatory Infection (at the proposed injection site) _____

Any Other Medical Diseases: _____

Previous Hospitalizations/operations: _____

Explain: _____

Medications

Aspirin	Yes ✔	No ✔
Anti-Inflammatory	Yes ✔	No ✔
Anticoagulants	Yes ✔	No ✔
Steroids	Yes ✔	No ✔
Non-Steroidals (i.e. Advil, Aleve, Celebrex)	Yes ✔	No ✔

Other: _____

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Supplements

Ginko Biloba	Yes ✔	No ✔
Vitamin A	Yes ✔	No ✔
Vitamin E	Yes ✔	No ✔
Garlic	Yes ✔	No ✔
Flax Oil	Yes ✔	No ✔
Fish Oil/Omega	Yes ✔	No ✔

Other: _____

I understand the information on this form is essential in determining 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 members responsible for any errors or omissions that I have made in the completion of the form.

Patient Signature:_____ **Date:** _____

DERMAL FILLER ADMINISTRATION CONSENT

Derma Filler is a gel of hyaluronic acid generated by streptococcus specie of bacteria, chemically cross linked with BDDE, stabilized and suspended in physiologic buffer at PH=7 and concentration of 20mg/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 min. Results last approximately up to 12 months, depending on the product is used.

Initials_____

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RISK AND COMPLICATIONS

It has been explained to me that there are certain inherent and potential risk and side effects in any invasive procedures and in this specific instance such risk 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.

Initials_____

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.

Initials_____

PREGNANCY, ALLERGIES

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

Initials_____

PAYMENT

I understand that this procedure is cosmetic and that payment is my responsibility. I hearby 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 risk and complications of the procedure.

Initials_____

PATIENT SIGNATURE: _____ DATE: _____

PRINT NAME: _____