MEDICAL HISTORY
Dermal Fillers

Name_____DOB_____Ht_____Wgt_____Date_____

Address_____

City_____State_____Zip_____

Home Phone_____ Work/Cell Phone_____

Primary Physician's Name and Number_____

_____

Please list all medications you are currently taking:_____

_____

List Vitamin Supplements you are taking:_____

_____List any Allergies:_____

*Collagen Tested_____Date_____Were there complications?_____

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

Multiple Severe Allergies/Hypersensitivity to medications Sensitivity/Allergy to Lidocaine
Autoimmune Disease History of Cold Sores Allergy to Beef /Dairy/Cow's Milk Products Lupus
Keloid Formation

List any OTHER MEDICAL CONDITIONS not listed above that you currently have or have had in past:_____

_____

Please list any previous hospitalizations/surgeries:_____

_____

WOMEN: 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 filler was used 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_____

Practitioner Signature_____Date_____

CONSENT FOR TREATMENT

DERMAL FILLERS

Treatment with Restylane, Juvederm, Perlane, or Collagen 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. These dermal fillers 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 these dermal fillers is fast and 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, discoloration 2) Post treatment infection associated with any transcutaneous injection 3) Allergic reaction 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 & 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 any of the above mentioned dermal fillers. 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 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.

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 on many factors including but not limited to: age, sex, tissue condition, my general health and life style conditions, and sun exposure. The correction, depending on these factors may last 3-6 months and in some cases longer. I 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 occur in my medical history I will notify the office.

Patient Signature	Date	Witness Signature	Date

MDY PRIMARY CARE MEDICINE, PL

DERMAL FILLER PRE-TREATMENT INSTRUCTIONS

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

If you have a history of Herpes (cold sores) with an outbreaks more than 4 times a year it is recommended that you are pretreated with medication. This office recommends Valtrex 2GM the day before or the day of the treatment and then another 2GM's 12 hours after the first dose. ***Please let us know that you need a prescription if you do not have this medication on hand.***

If you develop a cold / flu, cold sore, blemish, or rash, etc. in the area to be treated prior to your appointment, you must reschedule *(we will not treat you).*

It is recommended, if you have a special event or vacation coming up, schedule your treatment at least 2 weeks in advance.

It is recommended you discontinue use of Aspirin, Motrin, Gingko Biloba, Garlic, Flax Oil, Cod Liver Oil, Vitamin A, Vitamin E, or any other essential fatty acids at least 3 days to 1 week before and after treatment to minimize bruising and bleeding.

It is recommended that you 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. *(All of these factors may increase risk of bruising)*

It is recommended you discontinue Retin-A two (2-3) days before treatment to avoid increased redness and irritation.

Your Appointment is scheduled on: Date_____ Time_____

MDY PRIMARY CARE MEDICINE, PL

POST TREATMENT INSTRUCTIONS FOR DERMAL FILLERS

A few simple guidelines both pre and post-treatment can
make a difference between a good result and a fantastic one.

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.

Avoid Vigorous Exercise and Sun and Heat exposure for 3 days after treatment.

We recommend you AVOID Aspirin, Motrin, Gingko Biloba, Garlic, Flax Oil, Cod Liver Oil, Vitamin A, Vitamin E, or any other essential fatty acids at least 3 days to 1 week after treatment.

We recommend you not use Retin-A or like products *(ex. Kinerase, Tazarac)* two (2) days after treatment to avoid increased irritation and redness.

It is best to wear no makeup or lipstick until the next day. Earlier use can cause pustules. *If you must wear makeup we recommend a good quality mineral makeup.*

We recommend you 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

Please remember "One side may heal faster than other side".

Regarding your Lips: "Don't Love Them or Hate Them for 2 weeks. You must wait 2 weeks before retreating or correction.

****Please report any "increased pain and increased swelling", redness, blisters, or itching immediately should it occur following your treatment.****

I certify that I have been counseled in post treatment instructions and have been given a written copy of these instructions.

Patient Name_____Date_____

Patient Signature_____

PHYSICIAN – PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered will be determined by submission to arbitration as provided by FLORIDA Law, and not by a lawsuit or resort to court process except as FLORIDA Law provides for judicial review of arbitration proceedings. Both parties to this contract by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury; and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filling of any action in any court by the physician to collect any fee for the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and feed of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness feed, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of the judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joiner in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joiner any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of FLORIDA law, applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable FLORIDA statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the FLORIDA Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below: Patient's Initials: _____

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Print Name_____Signature_____Date_____

Medical Professional/Group Print Name_____

Representative Signature _____Date_____