INTEGRATED DERMATOLOGY of Montrose

Consultation & Medical History for Cosmetic Treatments

Please provide a current Drivers's License

Last Name: _____ First Name: _____
Address: _____
Phone: _____ Cell: _____ Work: _____
Date of Birth: _____ Age: _____ Email: _____
Referred by: _____
Primary Care Provider: _____ Phone: _____
Pharmacy: _____ Phone: _____
Emergency Contact: _____ Phone: _____

Reason for Consultation: (Please circle the areas of concern)
Lines/ wrinkles, texture, dryness, dull appearance, blotchiness/ uneven skin tones, freckles, brown sun spots, hair, acne, blackheads, scars, precancers, redness/blood vessels, frown lines, folds around nose/mouth, neck, chest, hands,
other:_____
_____

Previous Cosmetic Treatments: (Please circle all that apply)
Facials, microdermabrasion, chemical peels, laser, Botox, Fillers, intense pulsed light, fractional light, photodynamic therapy, hair removal, CO2 resurfacing, facelift, blepharoplasty, brown lift
Other:_____
_____

Current Skin Care Regimen/Products used:
Sunscreen Brand _____ SPF _____ Daily use? Y/N Sunscreen only when outside? Y/N
Cleansers, moisturizers, anti-aging creams, Retin-A, Vitamin C, Glycolic Acid, firming creams, lighteners, fade creams,
Other: _____
AM Regimen: _____
PM Regimen: _____
Do you have ANY current or chronic medical illnesses that we should know about? Y/N
Please List: _____
Do you have ANY allergies to medications, foods, latex or other substances? Y/N
Please list: _____
Do you take /use ANY medications, both prescriptions and non-prescriptions, herbal or natural supplements, or topicals on a regular or daily basis? Y/N
Please List: _____

Medical History Questionnaire

Y/N Do you have a history of "cold sores", herpes I or II, or hepatitis? Type: _____

Y/N Do you have a history of diabetes, hypertension, cholesterol or problems with wound healing?

Y/N Do you have any history of seizures?

Y/N Do you have a history of migraine headaches?

Y/N Do you have a history of keloid or hypertrophic scarring or abdominal scarring?

Y/N Do you any active infections or compromised ability to healing?

Y/N Do you take St Johns Wart or any anticoagulants?

Y/N Do you have any permanent make-up, implants or tattoos?

Y/N Do you have any open lesions in the area to be treated?

Y/N Have you taken Accutane in the last six months?

Y/N Have you had or are undergoing any treatments for cancer? Type of treatments _____

Y/N Have you used any exfoliating creams or products in the last 2 weeks? (Retin-A, Differin, Glycolic Acid, Alpha-Hydroxy Acid products)

Y/N Have you had mechanical epilation less than 4 weeks ago? (Plucking, tweezing, electrolysis, or sugaring)

Y/N Have you had any unprotected sun exposure, used self-tanning creams or tanning beds in the last 4-6 weeks to the area being treated?

Y/N Are you or could you be pregnant?

Y/N Are your periods regular?

To avoid misunderstanding please carefully read our Financial Policy listed here:

Cosmetic appointments require $100.00 deposit at least a week prior to the appointment. The balance is due prior to your treatment on the day of treatment. If you miss or cancel your appointment with less that 48 hour's notice, your deposit will be non-refundable and will apply to your missed appointment.

Signature: _____ Date: _____

Filler Consent Form

Informed Consent-Fillers, Restylane and Sculptra

Instructions: This consent form is designed to give you the information you need to make an informed decision about whether to undergo treatment with Hyaluronic Acid or Calcium Hydroxyapatite dermal filler for face wrinkles and folds, contour defects and /or lip enhancement. If you have any questions, please ask the provider or MA.

Introduction: Dermal filler treatments involve injections of purified Hyaluronic Acid or Calcium Hydroxyapatite; injectable dermal fillers eventually lose their form and wear down. While the effects of dermal fillers can last 6 months or longer, the procedure is still temporary. Ongoing treatments are required to maintain the improvements achieved with dermal filler. However, due to various factors that influence dermal breakdown, no guarantees can be made regarding how long correction will last in a specific patient.

Alternative Treatment: Alternatives to dermal filler treatments include but are not limited toother dermal fillers (collagen, fat synthetic polymers), laser resurfacing lift, laser, or no treatment at all.

Patients who may be eligible for dermal fill treatments: Patients with the following conditions may not receive dermal fill treatment: previous allergic reactions to injectable dermal fillers products, history of a serious allergic reaction (anaphylactic) multiple severe allergies, abnormal raised scarring or keloid formation, active inflammation, or infection in the treatment area (pimples, rash, hives, pregnancy, or nursing).

Certain conditions require caution with injectable filers and may preclude a patient from having received treatment: poor healing (due to diabetes or other conditions) and long-term use of Prednisone or steroid therapy. Recurrent viral infections such as herpes simplex (cold sores) may be activated by derma filler treatments. The provider or MA must be notified of these conditions prior to treatments: Aspirin, Ibuprofen or Fish Oil must be stopped two weeks prior to treatment to decrease bruising.

Risk: The possible risks, side effects and complications with dermal fillers include, but are not limited to: pain and tenderness during and after treatment at/around treated site which typically resolve within a few days to a week. Redness and swelling at/around the injection site are common, itchiness may also occur. These reactions are generally present immediately after treatment. On rare occasions pustules (acne-like lesions) may form. The provider of MA must be notified if symptoms persist for more than one week, if pustules are present or symptoms appear in a delayed fashion after treatment. Bruising usually resolves within 1-2 weeks after the injection. Patients taking medications that interfere with coagulation (aspirin, Ibuprofen) have and increase risk of bleeding and bruising.

Although rare, local tissue damage can occur with skin breakdown, scab formation and scarring in treated area. Visible raised areas and lumpiness at/around the treated site, grayish discoloration of the skin. These symptoms may persist from a few weeks to several months and may be permanent (rarely).

Failure to reduce a contour defect of wrinkle (under correction) or overcorrection. Placement of filler adjacent to or outside of the desired treatment area; undesired changes in facial contour. Asymmetry, where the correction of one side may be different than the correction on the other side of the face. Swelling at the time of the injection may create the appearance of asymmetry or under correction or asymmetry persists.

Dermal fillers may have an unpredictable duration of action and may last as long as anticipated or may persist in some areas longer than anticipated. A remote and rare risk is that of injecting dermal fills into a blood vessel which can block flow in the treated area or in distant areas cause tissue damage.

All the risks of dermal fillers may not be known. Providers are not responsible for any Hyaluronic acid or Calcium Hydroxyapatite risk, or unforeseen complications not yet discovered or not commonly known.

Information-Consent documents are used to communicate information about the purposed treatment of a disease or condition along with disclosure of the risks and alternative forms of treatment. The informed-consent proc attempts to define principles of risk disclosure that should generally meet the needs of most circumstances. However, informed-consent documents should not be considered all0inclusive in defining other methods of care

and risks encountered. Your physician may provide you with additional or different information, which is based on all the facts in our case and the state of medical knowledge.

Informed Consent-Fillers:

1. I consent to administration of any related treatments that may be deemed necessary or advisable for my procedure. This includes but is not limited to local anesthetic injections with Lidocaine 1%-2% with or without epinephrine and/or topical oral benzocaine preparations. The risks, side effects, complications of these anesthetics include, but are not limited to, skin irritation (itchy or redness) lightheadedness, rapid heart rate, fistula disturbances, tongue numbness. I will inform the provider or MA immediately if I experience any of these symptoms. I do not have an allergy to lidocaine or anesthetics. I understand Hyaluronic acid injections and any related treatments.
2. There is no guarantee that wrinkles and folds will be reduced. I understand that zi may require additional treatments to achieve correction.
3. I understand that the fees for Hyaluronic acid and Calcium Hydroxyapatite treatments are not covered by insurance. Should I require a touch-up treatment, I am responsible for the cost of the addition treatment.
4. I have fully read and agree to adhere to the pre-treatment instructions and post-treatment instructions. I understand that failure to carefully follow these instructions may affect my treatment outcome and increase the likelihood or severity of complications.
5. I authorize the taking of clinical photographs. Their use is for documentation of my "before" features.
6. I have fully disclosed all my medical history. I understand that it is my responsibility to inform and update the provider or MA staff of any change in my health status and medical history.
7. I understand that I must stop Aspirin, Ibuprofen, or Fish Oil two weeks prior to treatment to decrease bruising.
8. I am an adult of at least 18 years of age. My signature below certifies that I have fully read the consent form and understand the information provided to me regarding the proposed procedure. I have been adequately informed about the procedure including potential benefits, limitations, and alternative treatments. I have had enough time to consider the information and I have had all questions and concerns answered to my satisfaction. I understand and accept the risks, side effects and possible complications associated with Hyaluronic acid or Calcium Hydroxyapatite treatments.
9. I consent and authorize a trained provider to perform Hyaluronic acid or Calcium Hydroxyapatite treatments. This consent shall apply to all Hyaluronic acid or Calcium Hydroxyapatite treatments.
10. If I have any questions or problems after treatments, I will call the provider at 970-252-7444
11. THE INFORMATION HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:

1. The above treatment or procedure to be undertaken.
2. There may be alternative procedures to methods of treatment.
3. There are risks to the procedures to methods of treatment.

Cost/Fee

Payment for cosmetic procedure is requested at the time of service for all patients. You may request a price quote before treatment. Appointments will need to be reserved with a deposit of $100.00 due at time of scheduling. We request a 48-hour notice of cancellation for all scheduled cosmetic treatments. If less that 48-hour notice is given, the deposit may not be refunded.

Patient name (printed) Date

Patient Signature Date

Witness Signature Date