AUBURN NY ORAL SURGERY

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FACIAL FILLER INJECTION INFORMED CONSENT

_______________________________________ _________________________
Patient's Name Date of Birth

Thisform and your discussion with your doctor are intended to help you make informeddecisions about yourtreatment.As a member of the treatment team, you have been informed ofyour diagnosis, the planned procedure, the risks, benefits,and alternatives associated with the procedure, and any associated costs. Your doctor will be happy to answer any questions you may have and provide additional information before you decide whether to sign this document and proceed with the procedure.

Diagnosis: ____

Procedure:____

Alternative options: ____

1. I have been informed of and understand the known risks related to this treatment include but are not limited to:
    - Pain, bleeding, infection, bruising, pigmentation changes, delayed healing, scarring, skin or tissue death, worsened skin condition, allergic or adverse reactionto the injected materials, such as redness or abscess formation at the injection site, itching, cold sore eruption or flu-like symptoms;
    - Temporary swelling that will be noticeable for at least several hours, but perhaps as long as several days; skin lumpiness at the injection site, small bumps under the skin, visible bumps with redness, tenderness, skin discoloration or textural alteration;
    - Under correction or over correction resulting in unsatisfactory results;
    - Visual complications including significant vision loss and/or, in rare instances, blindness;
    - Injury to nerves, blood vessels or muscles resulting in weakness or loss of facial muscle mobility, possibly affecting appearance and expression, scabbing, shedding and shallow scarring. Such conditions may resolve over time, but in rare cases may be permanent.

Patient's Initials __________

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2. I have been open and honest with my doctor regarding my motivation for undergoing this procedure, and I realize these cosmetic results cannot guarantee an improved life. Subsequent changes in appearance may occur as a result ofaging, weight loss or gain, sun exposure, pregnancy, menopause, or other circumstances unrelated to the procedure. In addition, the results may not match my expectations and may vary between individuals. Future and/or additional procedures may be necessary to achieve desired results. I have been informed of and understand that follow up visits or care, additional evaluation, and treatment may be needed.

3. I have advised my doctor if there is a chance I might be pregnant or am lactatingor if I have any severe allergies or have had any allergic reactions to any previous facial filler. I attest that I have not taken Accutane within the last 12 months, do not have any bleeding disorders, and do not have permanent implants near the intended treatment area.The use of blood thinners, NSAIDS, steroids, vitamin A or E, Ginko Biloba, Fish Oil supplements, St. John's Wort, garlic and flax seed oil within 1 week of treatment might cause bleeding or increased bruising at the injection site.

4. Patient's Responsibilities

   I understand that I am an important member of the treatment team. In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications (including, but not limited to Aspirin, NSAIDS and Plavix), any allergies, recreational drug use, and pregnancy (if applicable). NOTE: It is important if you have had a stent and are taking Plavix that you inform the surgeon. Stopping Plavix may result in a heart attack, stroke and even death.

   I understand and accept that the doctor cannot guarantee theresults of the procedure.I had sufficient time to read this document, understand the above statements, and have had a chance to have all my questions answered. By signing this document, I acknowledge and accept the possible risks and complications of the procedure and agree to proceed.

____________________________________ ____________

Patient or Legal Representative Signature Date

Patient's Initials __________

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Patient's Name Date of Birth

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Print Patient or Legal Representative Name/Relationship

________________________________ ____________

Witness Signature Date

I certify that I have explained to the patient and/or the patient's legal representative the nature, purpose, benefits, known risks, complications, and alternatives to the proposed procedure. The patient and/or patient's legal representative has voiced an understanding of the information given. I have answered all questions to the best of my knowledge, and I believe that the patient and/or legal representative fully understands what I have explained.

______________________________ ____________

Doctor Signature Date

Patient's Initials __________