

Juvéderm™ Injectable Gel Consent Form

Name _____ Date: _____ Age: _____

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

**History of Anaphylaxis - Multiple Severe Allergies - Facial Acne - Facial Rashes
Hives - Herpes - Active Inflammatory process - Infection (at proposed sites) -
Autoimmune Disease - Immunosuppressive Therapy - Any other Medical Disease**

Explain: _____

Previous Hospitalizations/Operations: _____

Juvéderm™ Administration Consent

Juvéderm™ injectable gel is a family of nonanimal-sourced hyaluronic acid (HA) gels produced by innovative HYLACROSS™ technology. HYLACROSS™ technology produces a smooth-consistency gel, unlike the previous generation of HA dermal fillers, for a smooth, natural look and feel that lasts up to 6 months or longer.

Risks and Complications

It has been explained to me that there are certain inherent and potential risks and side affects 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, 2) Post treatment bacterial, viral, and/or fungal infection requiring further treatment, 3) Allergic reaction.

Photographs

I authorize the taking of clinical photographs. I understand my identity will be protected.

Pregnancy, Allergies

I am not aware that I am pregnant, have any significant Medical Diseases, or have any severe allergies.

I hereby voluntarily consent to treatment with Juvéderm™ injection for the condition known as: Facial Static Wrinkles. I have read the above and understand it. I accept the risks and complications of the procedure.

Patient Signature _____ **Date** _____

Juvéderm™ Patient History

Women: are you Lactating or Pregnant? Yes ___ No ___

Previous Juvéderm™ Yes ___ No ___ **Area:** _____
Date _____

Complications: Yes ___ No ___ **If yes,**
Explain: _____

Have you had other dermal fillers: Yes ___ No ___

Type of Dermal Fillers: _____ **Areas:** _____

History of Anaphylactic Shock: Yes ___ No ___

History of Allergies: _____

Current Medications: _____

Do you take any of the following?

(Please circle)

- Aspirin
- Anti-inflammatories
- Anticoagulants
- Steroids
- Non-Steroidal

(I.e. Advil, Aleve, Celebrex)

- Gingko Biloba
- Vitamin A
- Vitamin E

I understand the information on this form is essential to determine my medical and cosmetic needs and the provisions 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 member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature _____ **Date** _____