Fibroblast/Skin Tightening Consultation Record

Full Name:_____

D.O.B._____

Address:_____

_____

_____

Phone:
_____Cell:_____

E-mail:_____

Physician Name:_____

Phone Number:_____

Address:_____

_____

Occupation_____

What is your ethnicity (Irish, Italian, Asian, African, etc..)?_____

Do you tan, burn then tan, burn then peel?_____

Before proceeding with any Fibroblast/Plasma Treatment, you are required to complete the entirety of this form and sign thus giving your absolute consent of treatment. Additionally, you will need to disclose your full medical history, which will determine whether you are a suitable candidate for the proposed treatment. If DollFace determines you are not a good candidate, the procedure will NOT be performed. DollFace will discuss the procedure in full, including what is involved, benefits, explain any risks, the healing process, and advise upon any further treatment if/where necessary. You will be provided with written aftercare for you to keep and refer to as needed during the subsequence healing process.

In order to achieve your desired results, it is an ABSOLUTE MUST to follow aftercare!!

If you are unable to stay out of the sun, *DO NOT* continue with this procedure. If you have any contraindications, *DO NOT* continue with this procedure.

It is important you clearly mark any areas of this form you wish to have clarified or discussed further. It is ultimately your responsibility to ensure you understand in full, the procedure and the expected outcome BEFORE treatment begins.

Please read and carefully inital where indicated, only when you are happy to proceed. Ensure all points below have been discussed with DollFace. You are signing to state that you understand and accept these terms.

Terms of your treatment: (initial)

*You have chosen a cosmetic procedure that is not medically necessary. _____

*Fibroblast is an art process not an exact science therefore, exact shrinkage and tightening results cannot be guaranteed due to skin elasticity and an individual's healing process. _____

*You may be required to return for additional treatments before your overall procedure is deemed complete. The payment for any additional work, if applicable, will be agreed prior to the treatment commencing. Depending on the area of treatment, additional treatments, additional treatments cannot be performed until after 4-8 weeks from date of initial treatment. This is to allow the initially treated are to fully heal. _____

*Every clients skin type is different, and the healing process may lead to some discoloration of the skin. Microdermabrasion or another form of skin rejuvenation may be advised after the healing process is complete. _____

*After each treatment, some redness and swelling may occur. In some cases, there may be extreme swelling. Your specialist will reassure you throughout and endeavor to make you feel comfortable. ____

*You must adhere to the aftercare advice given to you following the procedure. This is very important and will reduce the risk of hyper/hypo pigmentation and post procedural infection upon leaving the office. You must let the treated area heal properly. AVOID ALL picking as this will hinder the healing process and could make the treatment appear uneven, blotchy or discolored thus requiring further work. ____

*Be aware that skin altering procedures such as plastic surgery, implants, injectables and weight gain may alter the fibroblast appearance. _____

Medical/Treatment History

What are your present skin concerns?_____

_____

What is your daily skincare routine?_____

_____

Products used on a regular basis?_____

_____

Do you receive professional skin care treatments?

When?_____

How often?_____

Treatments?_____

Have you received any skin tightening/lifting resurfacing before? _____

When?_____ Treatment Area?_____

Were you happy with the results?_____

Are you over 18?_____

Are you pregnant?_____

Are you nursing?_____

Are you under the influence of drugs or alcohol currently? _____

Please answer yes or no to the following questions. The details will then be discussed in confidence with DollFace.

Do you feel fit and well enough to have a Fibroblast treatment today? _____

Do you have any allergies or have you experienced any allergic reactions to medicines, products or numbing agents (Novocain, lidocaine)?_____

Are you currently taking any medications? _____If yes, please provide detailed list of medication, use, amount._____

_____

_____

Do you have or are you planning to have any injectables, fillers, or chemical peels in the near future?_____

Do you have any imminent vacation plans? _____

Have you tanned recently?_____Used topical tanners?_____Tanning enhancement pills?_____Spray tan?_____

When and how often?_____

Do you knowingly suffer from:

Any infectious disease?_____Epilepsy?_____Diabetes?_____Hemophilia?_____

High blood pressure?_____Respiratory issues?_____Panic attacks?_____

Depression?_____Anxiety?_____

Light headedness or fainting?_____ Keloids or have any problems with scars and healing?_____

Thyroid disorders?_____HV/AIDS?_____Hepititus?_____

Autoimmune disorders?_____

Lymphatic disorders?_____

Do you suffer from skin problems (eczema, psoriasis)?_____

If you suffer from any of the above, it is important that you notify your specialist, who can take necessary precautions to ensure you receive the best treatment and to avoid any risk to your health.

I understand the importance of my accurate and complete medical history. I understand that withholding any medical information, may be detrimental to my health and safety during and after my procedure. I understand that if there is any change in my medical history, it is my responsibility to inform DollFace.

Signature:_____Date:_____

Specialist:_____

Photographic Consent

I consent to photographs being taken before, during and after my procedure and being stored with my case file. _____.
I give my consent for use of promotional purposes. _____

Patch test/Waiver:

I understand that a skin patch test can determine whether I will experience a reaction to the products used by the specialist. I also understand that some skin types may hype or hyper pigment due to the procedure and a patch test is highly recommended 48 hour prior to the treatment.

I have undergone or been offered a patch test prior to my initial procedure. I therefor release the specialist from liability related to any hypo, hyper pigmentation or allergic reactions I may experience associated with either the treatment or applications of pretreatment creams or any other products used after the procedure, immediately or at a later date.

Sign:_____

Procedure Performed

Area_____

Cost_____

Procedure Consent:

My specialist has explained the terms and conditions of the procedure and I fully understand. I hereby give written consent to the specialist to carry out the Fibroblast treatment of my choice as requested by me on this consent and treatment agreement. Furthermore, I have read over policies and procedures in regard to cancelations and late fees and agree to these policies set in place.

Print:_____

Sign:_____

Specialist:_____Date:_____

Please tell us who we can thank for the referral today?_____