CONTOUR
by Joplin ENT

FILLER
Client Intake Form

CLIENT INFORMATION

Full Name: _____ Date of Birth: _____
Phone Number: _____ Email Address: _____
Address: _____
Emergency Contact Name: _____ Emergency Contact Phone: _____

MEDICAL HISTORY

Please check all that apply:

[ ] Pregnant or nursing
[ ] Autoimmune disorders
[ ] History of keloid scarring
[ ] Allergies to lidocaine or other anesthetics
[ ] Previous dermal fillers (date: _____)
[ ] Cold sores or herpes simplex
[ ] Diabetes
[ ] Bleeding disorders
[ ] Use of blood thinners

If any checked, please explain:

_____

SOCIAL HSITORY

_____

Do you smoke? [ ] Yes [ ] No Do you drink alcohol? [ ] Yes [ ] No

TREATMENT GOALS

What areas are you interested in treating?

[ ] Lip Volume
[ ] Lip Definition (Cupid's bow / Border)
[ ] Lip Symmetry
[ ] Other: _____

What are your expectations from this treatment?

_____

CONSENT & ACKNOWLEDGEMENT

By signing below, I confirm that:

- I have answered all questions truthfully and to the best of my knowledge.
- I understand the nature, risks, and possible side effects of lip filler treatment.

I give consent to receive the procedure and for my information to be used for treatment purposes.

Client Signature: **Practitioner Signature:**
Date: **Date:**

CONTOUR
by Joplin ENT

FILLER
Consent Form

CLIENT INFORMATION

Full Name: _____ Date of Birth: _____
Phone Number: _____ Email Address: _____
Address: _____

PROCEDURE OVERVIEW

Dermal fillers (such as hyaluronic acid-based fillers) are used to enhance the volume, shape, and symmetry. While results are typically temporary, they may last several months depending on the type of filler and individual factors.

Please read and initial each item below:

[ ] _____ I understand that results vary from person to person and are not guaranteed.

[ ] _____ I understand that mild swelling, bruising, redness, and tenderness are common and typically resolve within a few days.

[ ] _____ I understand that more serious but rare side effects can occur, including lumps, infection, allergic reaction, vascular occlusion (blockage of blood supply), or prolonged swelling.

[ ] _____ I have informed my provider of any medical conditions, allergies, or medications I am currently taking.

[ ] _____ I am not pregnant or breastfeeding at this time.

[ ] _____ I understand that I should avoid alcohol, blood-thinning medications, and strenuous exercise before and after treatment as advised.

[ ] _____ I give consent for before-and-after photos to be taken for medical documentation (check if you also approve use for marketing purposes: [ ] Yes [ ] No).

[ ] _____ I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

CONSENT & ACKNOWLEDGEMENT

I confirm that I have read and fully understand the above information. I understand the nature of the procedure, potential risks, and alternatives. I voluntarily consent to receive lip filler treatment today.

Client Signature: **Provider Signature:**
Date: **Date:**