White Salmon Family Practice

INFORMED CONSENT

COSMETIC and AESTHETIC DERMATOLOGY

By signing the attached consent form(s) you are agreeing that you have been informed of known risks, benefits and alternatives related to receiving the related cosmetic treatments.

PLEASE NOTE THAT IF YOU HAVE A SPECIAL EVENT PENDING WITHIN THE NEXT TWO WEEKS, YOU SHOULD DISCUSS THIS WITH US IN CASE IT IS NECESSSARY TO RESCHEDULE YOUR TREATMENT. BRUISING AND SWELLING CAN OCCUR, DEPENDING ON THE PROCEDURE.

NAME: _____

MAILING ADDRESS: _____

_____

BEST PHONE CONTACT # _____ E-MAIL: _____
(is this cell or landline?) (can we text you? _____)

Emergency Contact:
Name: _____

Phone: _____

DATE OF BIRTH: _____

HAVE YOU HAD ANY FACIAL COSMETIC DERMATOLOGY PERFORMED BEFORE? (Y) _____ (N)_____
(If yes, please explain) (continue on back if necessary)

_____

_____

DO YOU HAVE ANY ALLERGIES? _____

ARE YOU PREGNANT OR NURSING? _____

DATE: _____ SIGNATURE: _____

By initialing consent for your procedure today, you are agreeing that you have been informed of known risks, benefits and alternatives related to receiving the chosen cosmetic dermatology or aesthetic medicine treatment (s).
PLEASE NOTE THAT IF YOU HAVE A SPECIAL EVENT PENDING WITHIN THE NEXT TWO WEEKS, YOU SHOULD DISCUSS THIS WITH US IN CASE IT IS NECESSSARY TO RESCHEDULE YOUR TREATMENT.
BRUISING AND SWELLING CAN OCCUR, DEPENDING ON THE PROCEDURE. _____

Today's Procedure(s):	**Initial :**	**Date:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____

WHITE SALMON FAMILY PRACTICE – COSMETIC & AESTHETIC CONSENT

PATIENT NAME:_____

DOB: _____