Confidential Patient Information and Consent

Tammy Foster MD
415.793.8134

Name: ___________________________________ **Date of Birth**: _________________

Phone: _____________________ **Email**: ___________________________________

Address with zip: ____

Emergency Contact: ________________________________Phone: _________________

Medical History (circle): High Blood Pressure / Diabetes / Heart Disease /
Neurologic disease / Musculoskeletal disease / Prior serious skin infection /
Immune system disease / Blood Clot / Cold Sores, Herpes, Shingles
Other medical problems or diagnoses? ____
Medications including over the counter:
____
____ None (circle if not taking any medications)
Allergies and type of reaction: ____________________________ None (circle if no allergies)

Past injectable treatments and/or cosmetic surgeries:
____
Problems with those treatments: ____

Any other notes or concerns: ____

I will not have injections if I become pregnant. I will have injections while breast-feeding only after approved by my OB or pediatrician. To my knowledge, I am not allergic to lidocaine or albumin. If I have an immune system or neuromuscular disease, I have documented this above and have discussed and accepted the increased risk. I will update Dr. Foster about any new medical problems or medications.

I consent to this and all future treatments by Dr. Foster. I understand results are not completely predictable, and follow up visits may be needed for best results. I assume financial responsibility for the treatments I receive and any complication that may arise. I accept the risks including bruising, infection, droop, lumps, scars, asymmetry, pain, allergic reaction and even rare events like blindness or stroke. I accept responsibility for accident or injury while on the premises. I have had an opportunity for my questions to be answered, and I understand there are alternatives, including no treatment.

I have also read and agreed to the consent forms for individual procedures: Botox or Dysport, Dermal Filler/Sculptra, Kybella, and/or hyaluronidase.

Signed: ___________________________________ Date: _______________