Gairhan GDC
DENTAL CARE

Patient Name: _____

To the patient: You have the right to be informed about your treatment so that you may make a decision to undergo the procedure, knowing the risks and hazards involved.

I, _____, have received a consultation, consent to having Botox and/or Dermal Fillers carried out upon me.

I have been informed about the treatment, procedure, indication, expected results, and possible side effects. I understand that I may experience swelling, redness, tenderness, slight headache, pain and/or bruising that may occur for several days after my treatment; however, these symptoms will resolve. Rarely, an adjacent muscle may be weakened for several weeks after injections. I have been advised of the risks involved and the expected benefits of Botox and/or Dermal Filler.

Although the results are usually dramatic, I have been informed that this procedure is not an exact science and that no guarantees can or have been made concerning the expected results in my case.

I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons and that no guarantees can be made as to the exact results of this procedure. I understand that while every precaution will be taken to prevent complications and that while complications from this procedure are rare, they can and sometimes do occur.

I accept responsibility for any complications that may occur and thereby absolve Gairhan Dental Care and any associated person of any blame resulting therefrom.

I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

_____ _____

Client/Guardian Signature Date

_____

Witness