Kimberly Cockerham, MD
FACIAL AESTHETICS, LASERS & RECONSTRUCTIVE SURGERY
Zeiter Eye Medical Group, Inc.

Artefill Information and Consent Form

Name of Patient:_____ Date: _____

Age-related changes of the lips and mouth include atrophy of the lips and atrophy of the corners of the mouth resulting in downturn of lip corners. Another sign of aging is the development of nasolabial lines. Although the upper face can easily be rejuvenated with Botox, the lower face is less amenable to this treatment. To treat the entire aging face, a combination of Botox and injectable fillers is often most beneficial.

Artefill- Artefill is an injectable that is placed beneath unwanted wrinkles such as those around the mouth. It is the first non-resorbing filler that is approved for cosmetic use by the FDA.

Side Effects- Bleeding, tenderness, redness, bruising, or swelling may occur at the site of injection immediately during and a few days after the injections. Of concern is the delayed appearance of bumps (granulomas) under the skin later on. The incidence of this side effect is rare and it is treatable.

Artefill is contraindicated for people with prior history of injectable collagen allergies. A skin test is necessary one month before treatments can start. If you are allergic to the test, please inform our office.

My signature signifies that I am not pregnant, nursing an infant, or have any of the following allergies: collagen, lidocaine, or multiple severe allergies to a variety of substances. I also do not have a history of a bleeding disorder, abnormal scarring or an autoimmune disease. I am not taking immunosuppressants or blood thinners. I have told my physician if I have a history of oral herpes simplex (cold sores).

Alternatives- Alternative treatments include temporary or semi-permanent fillers such as Restylane or Sculptra.

Photography- I hereby give my consent to have photographs taken of all treated sites for diagnostic purposes and to accurately document the medical record in the usual and customary manner. I agree that these photographs are the property of Dr. Cockerham and my photographs may be used for teaching purposes or publication in scientific journals. It is specifically understood that in any such publication or use, I shall not be identified by name and every effort would be made to conceal my identity.

Consent- I voluntarily request treatment by Dr. Cockerham using Artefill. My questions regarding such treatment, its alternatives, its complications and risks have been answered by the doctor, her staff, and/or written information. I hereby give my unrestricted consent for the procedure. As the practice of medicine is not an exact science, no guarantees can be given regarding individual results.

_____ _____ _____

Signature of Patient Date Signature of Doctor