RECONSTRUCTIVE & AESTHETIC
SURGEONS, INC.

Sofwave Consult Form

Name:_____ DOB:_____ Age:_____ Gender: F/M

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____Work Phone:_____ Cell Phone: _____

Email Address:_____ Occupation: _____

How were you originally referred to Bella Via? (Please circle and add note if applicable)

Dr. Colville Dr. Zavell Website Friend: _____

Other: _____

What areas would you like to have treated? _____

What results would you like to see from your treatment? _____

What medications are you currently taking (including aspirin, vitamins, or herbal supplements):_____

_____

Please list all allergies, including medications: _____

_____

Are you pregnant, or breastfeeding? _____Y _____N

Do you have, or have you had any of the following conditions? Please check.

____Rosacea	____Acne Vulgaris (stg III-IV)	____Herpes Simplex/Cold Sores
____Warts	____Scleroderma	____Bacterial/Fungal Infections
____Open Lesions	____Solar Keratosis	____Skin Cancer
____ Metal stents	____Implanted electrical devices	____Migraines
____Bell's Palsy	____Hemorrhagic/bleeding disorders	____Mechanical or other implants
____Active or local skin disease	____Autoimmune disease	____Epilepsy

Other: _____

Are you currently under medical supervision for any of the following? Please check. If NO, initial here _____.

____Cardiac Condition ____Liver Disease ____HIV ____Auto-Immune Disorder

____Diabetes Type I/II ____Hemophilia ____Cancer

Are you currently taking, or have taken in the last 3 months any of the following? Please check.

____Isotretinoin ____Accutane ____Isotane

____Anti-Coagulants/Blood Thinners ____Antibiotics

Have you had any of the following procedures in the last 2 weeks on the area to be treated? Please check.

____Botox/Dysport/Xeomin ____Dermal Fillers (Voluma, Juvederm, Restylane) ____Skin Tightening

____Chemical Peel (Glycolic, Lactic, Salicylic Acid) ____Ablative/Non-ablative resurfacing laser treatment

____Lipoplasty in the face or neck regions ____Facelift or blepharoplasty or browlift

I understand that there are many types of treatment for fine lines and wrinkles and that each has its own benefits, risks, and potential side effects. The treatment with the Sofwave System is a non-invasive, dermatological procedure performed by a healthcare provider who is trained on the use of this product.

By completing this Patient Consent Form, I am consenting to the treatment with the Sofwave System and acknowledging that I have read and understood the following points and all information contained in this form and made an informed and careful decision to receive the treatment with the Sofwave System.

- The Sofwave System is used to treat wrinkles and fine lines on the skin.
- The procedure is non-invasive and uses an ultrasound beam.
- The Sofwave System delivers ultrasound energy to the skin. The heat from the ultrasound stimulates new collagen and elastin to form.
- I understand that there may be discomfort during the treatment when the ultrasound beam is being delivered.
- My healthcare provider may choose to apply a topical anesthetic and/or administer nitrous oxide.
- Following treatment, there may be some redness and/or swelling on my face that may last for a few hours; there should be no pain when the procedure is completed while post-procedure discomfort or tenderness is possible.
- My experience in receiving the treatment and the results of my treatment may be different from others.
- While receiving treatment with the Sofwave System can provide potential benefits for me, there are also potential risks/complications associated with the treatment. These risks include, but may not be limited to, the following:
    - Burn
    - Significant pain
    - Tenderness
    - Changes in skin pigmentation
    - Ulceration/Erosion
    - Bruising
- For additional information about the Sofwave System, I can call toll free 1-855-sofwave or log on to https://sofwave.com. After learning about the Sofwave System, I choose to use the Sofwave System.

Patient Signature: _____ Date:_____

Provider Signature: _____ Date:_____