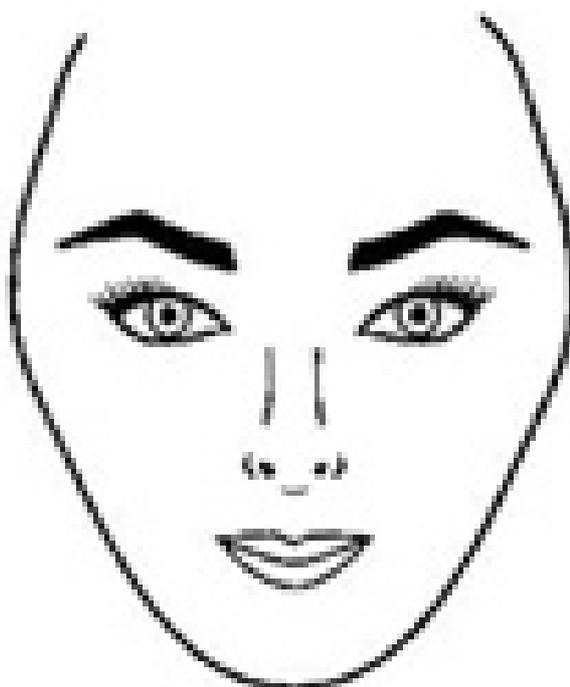


Dermal Filler Patient Treatment Record

Patient Name:	Patient DOB:
Date of Treatment: Time of Treatment	Practitioner: Signature:



Product:	Batch:	Exp:	Volume:	POIG
Additional Product:	Batch:	Exp:	Volume:	POIG
LA & Administration:	Batch:	Exp:	Volume:	POIG

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