Diagnosis and Treatment Plan – Level III Dermal Filler

Patient Information

Patient Name: ______________________________ Date: ____________________

Treating Doctor Name: ______________________________

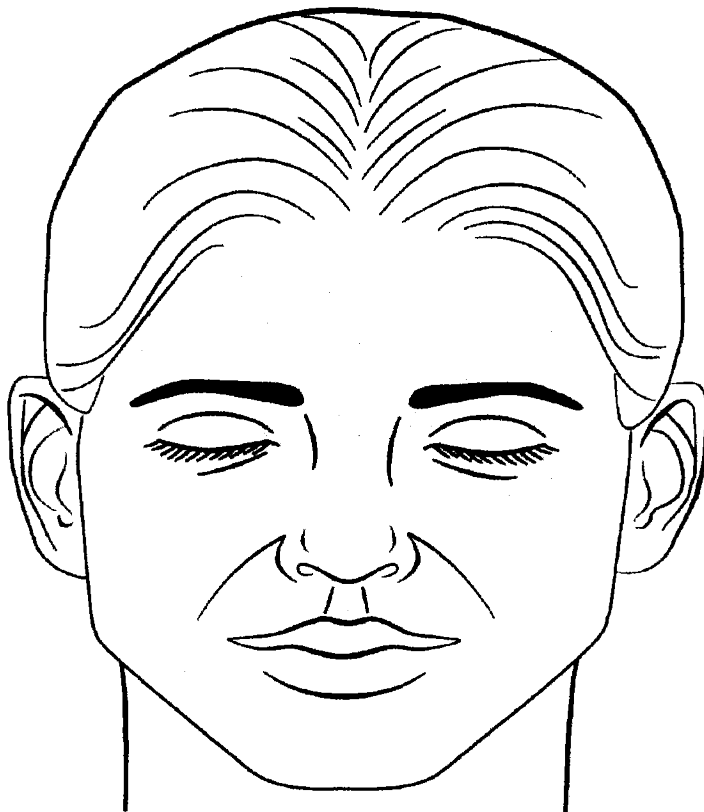
Health History Completed? Yes ☐ No ☐ Date: ______________ Doctor Initial: ________

Dental / Head and Neck Examination Completed? Yes ☐ No ☐ Date: __________ Doctor Initial: _______

Informed Consent Completed? Yes ☐ No ☐

Diagnosis ICD-10 Codes (Check all that apply)

- ☐ K03.0 Excessive attrition
- ☐ K03.81 Cracked tooth
- ☐ K06.0 Gingival recession
- ☐ M26.00 Anomalies of jaw size
- ☐ M26.11 Maxillary asymmetry
- ☐ K08.109 Loss of teeth
- ☐ M26.9 Dentofacial anomalies
- ☐ K13.0 Diseases of lips
- ☐ K13.70 Cheek/Lip biting
- ☐ K08.419 Loss of teeth trauma
- ☐ M26.12 Jaw asymmetry
- ☐ M26.50 Dentofacial abnormal funct
- ☐ _____ Other
- ☐ _____ Other
- ☐ _____ Other



Muscle	Filler Used	Volume Used ml
(R) Nasolabial Fold		
(L) Nasolabial Fold		
(R) Marionette Line		
(L) Marionette Line		
Upper Lip		
Lower Lip		
(R) Oral Comm		
(L) Oral Comm		
Philtrum		
(R) Cheek		
(L) Cheek		

Total volume used: __________