SOLARIS
Laser & Skin Care

CLIENT INFORMATION AND CONSENT FORM: SKIN CARE

Name _____ Date of Consultation _____

Address _____

City _____ State _____ Zip _____

Home phone (____) _____ Cellular phone ( ) _____

E-mail _____ Date of birth _____

Emergency contact and telephone number _____

How did you find out about us? Name of person / website / other: _____

What is your goal for today's visit and/or future visits? _____

Are you using any blood/skin thinning products and/or drugs? Yes / No

Are you exposed to the sun daily or are you considering spending more time in the sun soon? Yes / No

Do you use a tanning bed? Yes / No If yes, how often and last time: _____

Have you been under care of a dermatologist or other medical professional in the last year? Yes / No If yes, please explain: _____

Please list any other illness or condition you are currently being treated for by a medical professional:

_____

Have you had any recent surgery, including plastic surgery? Yes / No If yes, explain: _____

_____

Have you ever been treated for cancer? Yes / No

If yes, when and what types of therapies were used?

_____

Have you had any piercings, tattoos, or permanent makeup? Yes / No If yes, where on your person?

_____

Do you smoke? Yes / No

Do you follow a restricted diet? Yes / No If yes, please specify: _____

_____

Do you follow a regular exercise program? Yes / No

What is your stress level? ____High ____Medium ___Low

Have you used an acne medication? Yes / No If yes, when? _____ Which drug? _____

List any other medications you are presently taking: _____

List any over-the-counter medications (including vitamins, herbal supplements, aspirin, etc.) that you take regularly: _____

List your daily consumption of: Water _____ Caffeine _____ Alcohol _____

Do you form thick or raised scar from cuts or burns? Yes / No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes / No If yes, describe: _____

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Do you experience any problems sleeping? Yes / No How many hours do you sleep each night? _____

Do you wear contact lenses? Yes / No

Do you have any metal implants or wear a pacemaker? Yes / No

Do you suffer from: Claustrophobia? Yes / No

Sinus problems? Yes / No

Are you taking oral contraceptives? Yes / No

If yes, please specify: _____

Any recent changes to or from your contraceptive treatment? Yes / No If yes, what and when?

_____

Are you pregnant or trying to become pregnant? Yes / No Are you lactating? Yes / No

Do you have any problems relating to menopause?

Yes / No If yes, please explain:

_____

Have you ever had an allergic reaction to any of the following?

(Please check all that apply and explain)

- Cosmetics
- Medicine
- Food
- Animals
- Sunscreens
- Iodine
- Pollen
- AHAs
- Fragrance
- Shellfish
- Latex
- Drugs
- Other: _____

If yes, please explain: _____

Have you used any Alpha Hydroxy Acid (AHA) or glycolic products in the past week? Yes / No

Are you using/have you used Retin-a, Renova, Accutane, Adapalene, Differin, Retinol, or Vitamin A derivative products? Yes / No

Have you ever had any adverse reactions to a skin care treatment or product? Yes / No

If yes, please explain: _____

Have you ever had an adverse reaction after using any skin care product?

- Rash
- Irritation
- Peeling
- Sun sensitivity
- Breakout

If yes, please explain: _____

Have you had any of these health conditions in the past or present?

(Please check all that apply and provide additional information in the space provided)

- Cancer
- Hormone imbalance
- Systemic disease
- High blood pressure
- Spinal injury
- Hyroid condition
- Hysterectomy
- Diabetes
- Heart problem
- Varicose veins
- Arthritis
- Eczema/Psoriasis

- Epilepsy
- Seizure disorder
- Fever blisters
- Hepatitis
- Herpes
- Frequent cold sores
- Immune disorders
- HIV/AIDS
- Lupus
- Any active infection
- Metal bone pins or plates
- Phlebitis, blood clots,
- Poor circulation
- Blood clotting
- Asthma
- Psychological treatment
- Skin diseases/skin lesions
- Insomnia
- Keloid scarring
- Skin disease/skin lesions
- Headaches (chronic

Additional information: _____

_____

Please note that skin care treatments can have certain side effects, such as redness, rash, swelling, tenderness, etc.

I have read the above information and if I have any concerns, I will address these with my esthetician. I give permission to my esthetician to perform the skin care procedure we have discussed and will hold her and her staff harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as possible. I have read and understand the post-treatment home care instructions. I am willing to follow recommendations made by my esthetician for a home care regimen that can minimize or eliminate possible negatives reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home products/ post-treatment care, I will consult the esthetician immediately.

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. I understand the procedure and accept the risks. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (printed) _____

Client Name (signature) _____ Date _____

Esthetician _____ Date _____

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Microdermabrasion, and Chemical Peels Consent

My signature below constitutes acknowledgement that:

I _____ consent to and authorize members of the Solaris Laser & Skin Care to perform one of the following procedures: Microdermabrasion, Acid or Chemical Peels and related services on me.

Procedure elected is:_____ Body Area:_____

Those procedures involve the use of a different modalities to remove the top layers of the skin. This treatment should be used as part of a complete skin care program to maximize the overall benefits. A skin care program has been recommendation to me as part of this treatment.

_____ Initials

The nature and purpose of the treatment has been explained to me, and any questions I have regarding treatment have been answered to my satisfaction.
_____ Initials

I understand that the treatment may involve the risk of complications or injury from both known and unknown causes and I freely assume these risks. Possible side effects of the treatment area can include mild redness of the skin, irritation, local swelling, mild discomfort or tenderness, pimple-like bumps, dry skin, lightening of the skin, infection, scarring, peeling, and activation of cold sores.

_____ Initials

I certify that I have read this entire consent and that I understand and agree to the information provided in this form. I certify that I an a competent adult of at least 18 years of age, or that, if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment. This consent freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns.

_____ Initials

I agree to adhere to all safety precautions and regulations during the skin treatment.

I have received and understand the post care recommendations as follows: no sun exposure for 48 hours, use gentle cleanser only, acid washer (if desired) may be resumed 48 hours after treatment._____ Initials

Patient Signature:_____ Date: _____/_____/____

Parent/Legal Guardian: _____ Date:_____/____/_____

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Scheduling Policy

Due to the popularity of our services, we have found it necessary to implement the following policy regarding the scheduling of appointments. Once scheduled all appointments require a minimum of 24-hour notice for cancellation.

Failure to follow this policy will result in the following:

Missing 1 appointment without notice: $ 25.00 Charge.
Missing 2 appointments without notice: $ 50.00 Charge.
Missing 3 appointments without notice: $ 75.00 Charge.
No future appointments will be honored until the above fees are paid.

Credit Card information will be collected in registration and will be used **only** for missing appointments.

For Complimentary and Gift Certificate Appointments:

Missing ANY complimentary appointment without a 24-hour notice will result in Complete Forfeiture of the appointment.
Gift Certificates are subject to the same charges as regular appointments.

I have read and fully understand this policy and agree to follow the terms within.

Credit Card Info: **Master Card** ____ **Visa** ____

Card Holder Name: _____ **Card Number:** _____

Expiry Date: _____ **CVS #** _____

SIGNATURE: _____

DATE: _____

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Aesthetic Client Log

Date	Treatment	Comments