BARE BEAUTY

laser + skin studio

patient profile

Name: _____ DOB: _____ Age: ____ Sex: ____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ E-mail: _____

About you:

What is your hereditary background? (Check all that apply)

- ☐ Nordic
- ☐ Scandinavian
- ☐ Irish
- ☐ English
- ☐ Asian
- ☐ Mediterranean
- ☐ Hispanic
- ☐ Native American
- ☐ Middle Eastern
- ☐ African American
- ☐ Other: _____

Natural eye color: _____
Natural hair color: _____
Do you consider your skin (Check all that apply):

- ☐ Normal
- ☐ Dry
- ☐ T-Zone
- ☐ Combination
- ☐ Thick
- ☐ Thin
- ☐ Saggy

- ☐ Firm
- ☐ Oily
- ☐ Acne
- ☐ Comedones/Blackheads
- ☐ Milia
- ☐ Cysts
- ☐ Breakouts
- ☐ Acne-scarred
- ☐ Large pores
- ☐ Small pores
- ☐ Rosacea
- ☐ Eczema
- ☐ Freckled
- ☐ Sun-damaged
- ☐ Melasma
- ☐ Hyperpigmentation
- ☐ Hypopigmentation
- ☐ Uneven/Blotchy
- ☐ Mature
- ☐ Wrinkled
- ☐ Patchy dryness
- ☐ Sallow
- ☐ Psoriasis
- ☐ Dehydrated/Lacking moisture
- ☐ Asphyxiated
- ☐ Telangiectasia/Broken surface capillaries

What are the changes you'd most like to see in your skin?

_____

_____

_____

Lifestyle:

Are you pregnant or lactating? (Please consult with your obstetrician. Only the **Oxygenating Trio®** , **Detox Gel Deep Pore Treatment** or **Hydrate: Therapeutic Oat Milk Mask** are appropriate.)

- ☐ Yes

☐ No

Do you wear contact lenses? (**Remove contacts** if eyes are sensitive or if having microdermabrasion

☐ Yes

☐ No

Do you currently have a sunburned/windburned/red face?

☐ Yes Why? _____

☐ No

Are you in the habit of going to tanning booths? (If within the past 14 days, decline treatment. This practice should be discontinued due to increased risk of skin cancer and signs of aging.)

☐ Yes

☐ No

Do you participate in vigorous aerobic activity or sports?

☐ Yes What type? _____

☐ No

Do you smoke or use tobacco?

☐ Yes

☐ No

What kind of work do you do? _____

On average, how many hours per week do you spend outdoors? _____

Medical / Treatment history:

Do you currently use depilatories or wax? (Discontinue use five days pre- and post-treatment.)

☐ Yes

☐ No

Have you had a chemical peel or any type of procedure with a medical device?

☐ Yes

☐ No

Within the last 14 days?

☐ Yes What type? _____

☐ No

Do you have regular collagen, Botox® or other dermal filler injections? (Peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.)

☐ Yes

☐ No

Have you recently had laser resurfacing or facial surgery?

- ☐ Yes
- ☐ No

Describe: _____

When? _____

Are you currently taking any medications, topical or otherwise?
(Tretinoin/Retin-A®/Renova®/Differin®/Tazorac®/Avage®/EpiDuo®/Ziana®)

- ☐ Yes
- ☐ No

Which one(s)? _____

For how long? _____

What strength? _____

(High percentages of certain ingredients may increase sensitivity. Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)

Have you undergone Accutane® therapy (isotretinoin)?

- ☐ Yes
- ☐ No

(If you are currently using Accutane® therapy (isotretinoin), please consult with your dispensing physician.)

(If you are no longer using Accutane® therapy (isotretinoin), it is OK to apply ONE layer of **Ultra Peel® I**, **Sensi Peel®**, **Advanced Treatment Booster**, **Oxygenating Trio®**, **Hydrate: Therapeutic Oat Milk Mask** or **Revitalize: Therapeutic Papaya Mask**.)

Do you develop cold sores/fever blisters?

- ☐ Yes Last breakout? _____
- ☐ No

Are you allergic/sensitive to (check all that apply)

- ☐ Milk
- ☐ Apples
- ☐ Citrus
- ☐ Grapes
- ☐ Aloe vera
- ☐ Aspirin
- ☐ Perfumes
- ☐ Latex
- ☐ Hydroquinone
- ☐ Mushrooms

If any other allergies, what? _____

Have you ever used any other products that caused a bad reaction?

- ☐ Yes Describe: _____
- ☐ No

Patient signature: _____ Date: _____

Clinician signature: _____ Date: _____

consent form

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: pregnancy (if so, consult your physician prior to treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters, or use of topical and/or oral prescription medications such as: tretinoin, Retin-A®, isotretinoin, Accutane®, Differin®, Tazorac®, Avage®, EpiDuo® or Ziana®.

I understand there may be some degree of discomfort such as stinging, pin-prickling sensation, heat or tightness.

I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc.

I understand I may or may not actually peel and that each case is individual. I understand that the amount of peeling does not correlate with degree of improvement.

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.

I understand that to achieve maximum results, I may need several treatments.

I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the physician/clinician who performed the treatment.

I agree to refrain from tanning in tanning beds or outdoors while I am undergoing treatment, and during the 14 days prior to and following the end of treatment. This practice should be discontinued due to the increased risk of skin cancer and signs of aging.

I understand that extended direct sun exposure is prohibited while I am undergoing treatment, and the daily use of sunscreen protection with a minimum SPF of 30 is mandatory.

I have not had any other chemical peel of any kind within 14 days of this treatment. I understand I cannot have another chemical peel within 14 days of this treatment, whether it is performed at this location or any other location.

I understand that I should follow my clinician's recommendations for post-procedure skin care to minimize side effects and maximize results.

I hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-peel care instructions as I am directed.

Signature: _____ Date: _____

Initials: _____

Signature of Clinician: _____

Signature of Witness: _____

Continued Treatment Consent

Date	Initials

Date	Initials

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CANCELLATION/NO-SHOW POLICY

48-hour notice: Required to cancel or reschedule without charge.

Late cancellation: Less than 48 hours' notice will result in a charge of $50.

No call, no show and same-day cancellation: Full payment of the service cost will be charged. A session may be taken away from a package.

Late arrivals: Clients arriving more than 10 minutes late may be subject to a shortened service or rescheduling, at the provider's discretion, and may incur a late fee/ cancellation fee.

Card on file: A valid credit card is required to hold an appointment, and cancellation fees will be charged to the card on file.

Exceptions: In the event of a true emergency, all or part of the cancellation fee may be applied to future services.

When you book an appointment with me, that time is reserved specifically for you. By canceling or rescheduling with short notice, you're not only taking away a spot that could've gone to another client, but you're also affecting my business's overall productivity and revenue. Your consideration and prompt communication regarding any changes or cancellations allow me to better serve you and other clients.

I have read and agree to the terms of the CANCELLATION/NO-SHOW POLICY

_____ _____

NAME (Please print) SIGNATURE

_____ _____ _____

CREDIT CARD # EXP. CVV

*NO REFUNDS AND TREATMENTS ARE NON-TRANSFERABLE