Client Information

First Name_____ M.I.____ Last Name _____ Age:___ Sex: M /F

Home Address _____ Date of Birth: ____ /____/____

City_____ State _____ Zip_____

Cell Phone: _____ Occupation: _____

Email: _____

Allergies/Reaction: _____

Emergency Contact: _____ Telephone:_____

How did you hear about ***Capital Laser***? Google,Yelp,Friend/Family,Social Media:

_____

1. What areas on your body are you interested in treating? _____

2. What other treatments, if any, have you tried? _____When: _____

3. Please circle the following if applicable: sunburn windburn self-tanner tanning bed

4. Have you used Renova or Retin A, Alpha-Hydroxy, glycolic acid? When/Where?_____

5. Are you or have you ever used Accutane? _____ When: _____ Dosage____

6. Are you currently taking any of the following? __ Tetracycline __ Bactrim__Hydrochlorothiazide

7. Are you currently taking any depression medications or other mood-altering medication? _____
Why?_____

8. Please list any other medications or herbal supplements that you are currently taking (including topical):
_____

Medical History:

Please put a check (√) next to a past or current medical condition(s):

- ❑ Lupus or other autoimmune deficiency
- ❑ Currently Pregnant/breastfeeding
- ❑ Bleeding abnormalities
- ❑ Keloid or very thick scarring
- ❑ Psoriasis or Vitalgo
- ❑ Herpes simplex
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Scars that turn white or brown
- ❑ Dark spots after pregnancy, skin injury
- ❑ Hirsutism
- ❑ Transplant Anti-Rejection Drugs

This information is true to the best of my knowledge.

Signature: _____ Date:_____

Please continue reverse side

Client Information

Client Treatment Consent and Release

I acknowledge that beauty treatments, such as Laser Hair Removal procedure is not an exact science and no specific guarantees can or have been made concerning the outcome. I understand that some clients experience more change and improvement than others. I understand that laser procedure is purely elective; I undergo this procedure solely at my request. I understand that there is no guarantee, warranty, or assurance with this procedure and that hair may regrow for known or unknown reasons and conditions.
I also understand and agree to assume the following risks and hazards which may occur in connection with any particular treatment including but not limited to unsatisfactory results, soreness, poor healing, discomfort, redness, blistering, nerve damage, scarring, infection, change in skin pigmentation, allergic reaction, muscle damage, and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured, and any additional insureds, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive.

I have fully disclosed on my client intake form any medications, previous complications, or current conditions that may effect my treatment. I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties.

X _____

Client Signature

Date:

Printed Name

Model Release

In consideration for treatment received, I hereby grant permission to the individual or company that provided my treatment to use any photographic treatment records for the purposes of clinical and statistical studies, advertising, or promotion without any additional compensation to me.

X _____

Client Signature

Date:

Printed Name