



I authorize Allen Aesthetics and laser Center and its designated staff to perform Laser Hair Removal, IPL Fotofacial, Skin Tightening, Microdermabrasion, Pixel, Tattoo Removal and/or Vein Therapy on my body. I understand that these services are FDA-approved. The possible adverse reactions which are as follows:

PAIN:

The laser causes mild discomfort, which can be minimized by applying an anesthetic cream approximately one hour before each treatment.

BLISTERING:

Burning may occur in skin that is tan. Although rare, blistering is possible as is hypo- or hyper-pigmentation (lightened or darkened areas of skin).

CRUSTING:

If superficial crusts form, they should resolve with the gentle care as described in the aftercare instructions.

PIGMENT CHANGES:

Temporary color changes such as hyperpigmentation, which is a brown discoloration, or hypopigmentation, which is a skin lightening, may occur. While these can take 3 to 6 months to resolve, they rarely lead to permanent scarring (under 1%).

EYE PROTECTION:

Protective eyewear must be worn by everyone present during treatments.

PERSISTENCE OF HAIR:

Evaluation of Laser Hair Removal is on-going, but studies and clinical experience suggest that multiple treatments produce long-term hair loss. Although some clients will respond better than others, most clients will experience progressive hair loss with each treatment.

By signing below, I acknowledge that I have read the adverse reactions above and I feel that I have been adequately informed of the risks of my treatment. Before each treatment I will inform the laser technician if I have taken any new medications since my last treatment or if I have tanned the areas to be treated either by sunlight or artificially. I understand that some medications can make my skin photosensitive and either of the aforementioned conditions could cause the laser to damage my skin. I also agree to comply with the recommended aftercare guidelines which are crucial for healing, prevention of scarring and hyperpigmentation. I understand that I will need 8 treatments for hair removal. I hereby release Allen Aesthetics and Laser Center, its medical staff and the specific technician from liability associated with the above.

Client signature

Date



Medical History

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Circle one: Male or Female

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Pharmacy name/location/number: _____

How did you hear about us? _____

Reason for today's visit: _____

Do you have any particular skin problem or concerns? _____

Do you have any known allergies? _____

Please list any medications, including prescription and/or over-the-counter medicines you are presently taking (oral and topical): _____

Please list any past/present medical conditions or surgeries: _____

List previous types of hair removal/ laser procedures used for the area(s) you want treated (e.g. waxing, electrolysis, shaving, depilatories, laser, photofacial, vein, hair removal, acne, rosacea, hyperpigmentation): _____

When: _____

List previous types of cosmetic procedures (chemical peel, microdermabrasion, botox, collagen injections, sclerotherapy, micropigmentation-permanent-make-up, etc.):

_____ When: _____