ALASKA BREAST & COSMETIC CENTER

Health. Hope. Confidence.

PATIENT CONSULTATION & RELEASE FORM

Please read carefully, complete, sign and date this form prior to your treatment

NAME: _____ DOB:_____ DATE: _____

Select if applicable:

☐ HYDRAFACIAL™ ☐ BLUE LED LIGHT THERAPY ☐ RED LED LIGHT THERAPY

☐ MICRODERMABRASION ☐ Ultherapy ☐ Chemical Peels ☐ LYMPHATIC/MASSAGE THERAPY

SECTION 1: MEDICAL INFORMATION

Do any of the following conditions relate to you?

Do you have any of the following allergies?

☐ Shellfish ☐ Sulfur ☐ Other (Please list) _____

☐ Aspirin ☐ Preservatives _____

YES	NO	Contraindications
☐	☐	Accutane or other similar medication
☐	☐	Autoimmune disease, HIV, Lupus, Hepatitis
☐	☐	Blood thinners – Heparin, Coumadin, Warfarin, Plavix, etc.
☐	☐	Breast Feeding, Pregnancy
☐	☐	Cancer or post-cancer treatments
☐	☐	Cardiovascular problems
☐	☐	Cold sores or fever blisters without pre-medication
☐	☐	Cortisone or steroid injections
☐	☐	Cosmetic injections, fillers or implants (i.e. Botox®, Dysport, Restylane, Juvederm)
☐	☐	Eczema, Psoriasis
☐	☐	Enlarged or painful glands
☐	☐	Epilepsy
☐	☐	Facial waxing services within 7-14 days
☐	☐	Heart ailments
☐	☐	High Blood Pressure
☐	☐	Inflammatory conditions
☐	☐	Irregular, pigmented moles, warts or growths, unidentified facial growth or marks
☐	☐	Keloids, pigmented scars, ice pick scars, new scar tissue
☐	☐	Laser procedures, Chemical Peels, Dermabrasion, Microdermabrasion
☐	☐	Light sensitive medication
☐	☐	Loose, thin, aged skin
☐	☐	Lymphatic disorder, inflammation of lymph vessels, lymphedema
☐	☐	Medications: _____
		_____
☐	☐	Pacemaker or metal implants
☐	☐	Phlebitis, varicose veins
☐	☐	Recent accident or serious injury
☐	☐	Recent surgical or dental procedure
☐	☐	Rosacea, Telangiectasia/Couperose
☐	☐	Retin-A, Retinol

YES	NO	Contraindications
☐	☐	Skin abrasions or lesions
☐	☐	Stage III or IV acne
☐	☐	Skin-lightening or bleaching agent
☐	☐	Sunburn
☐	☐	Swollen or Infected tonsils
☐	☐	Thyroid conditions
☐	☐	Type I diabetic
☐	☐	Under medical care for an existing or suspected condition or disease
☐	☐	Viral infection, Influenza
☐	☐	Other contraindication at discretion of Doctor or Medical Aesthetician

_____

_____

If you answered YES to any of the above questions, please explain:_____

_____

_____

_____

_____

My interest in skincare treatment is primarily for (i.e. skin rejuvenation, acne, hyperpigmentation:, scarring, etc.)

_____

_____

_____

Specify your areas of concern (i.e. eyes, forehead, etc.)

_____

_____

_____

PHYSICIAN/MEDICAL AESTHETICIAN COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SECTION 2: PATIENT CONSENT FORM

(Please initial each acknowledgment line below)

_____ 1. I acknowledge that I have not used Accutane or **any** medication for the same purpose during the last 12 months.

_____ 2. I acknowledge that if I have ever had a cold sore or fever blisters, I should consult with my Physician or pharmacist for a pre-use medication to help avoid a possible breakout. That medication should be used each day for two days before, same day, and two days after any aggressive facial exfoliation treatment.

_____ 3. I acknowledge that there is no guarantee that dark discoloration of my skin will be reduced or fade. Pigmentation may improve or darken with successive treatments. I acknowledge the need for proper skin care home regimen.

_____ 4. I acknowledge that my skin might experience temporary irritation, tightness, redness or slight swelling which usually dissipates within 72 hours depending on skin sensitivity.

_____ 5. I have disclosed my history of allergies above.

_____ 6. I acknowledge that if I am allergic to one or more of the ingredients in the products used, I may experience allergic reactions.

_____ 7. I acknowledge that if I fail to use a minimal sunscreen (SPF 30) and follow the directions for use, I am more susceptible to sunburn, sun damage and hyperpigmentation. I should avoid excessive sun exposure, especially between 10am – 2pm.

_____ 8. I acknowledge that this treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied.

_____ 9. I acknowledge that I should avoid use of aggressive exfoliation, waxing and products containing acids that are not part of the recommended take-home regimen for 2-4 weeks following the treatment.

_____ 10. I acknowledge that I should avoid use of Retin-A type products for a period of time recommended by my Physician or Medical Aesthetician during and following the treatment.

_____ 11. I acknowledge that I am not pregnant/lactating.

_____ 12. I hereby agree to have the treatment performed and agree that I will follow all pre and post treatment instructions.

_____ 13. I acknowledge that I have answered all questions truthfully and completely.

_____ 14. I release Alaska Breast and Cosmetic Center, management and staff of Mary Jo Wright, MD from any liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

_____ 15. I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes. I acknowledge that my name will not be used to identify these photographs without my written approval.

By signing below, I certify that I have read and fully understood the contents of this consent form, and that the information I provided above are complete, accurate and up-to-date to my knowledge.

Patient Signature: _____ Date: _____

Medical Aesthetician Signature: _____ Date: _____

Adopted: 04/2018