

10:20 AM Wed 22 Apr

91%

Cancel

Waxing Consultation

What's your name?

First name

First name

Last name

Last name

Email address (optional)

SMS Number (+64) (optional)

Date of birth (optional)

Tap here to select a date

Do you suffer from any of the following ? (optional)

☐ Allergies

☐ Diabetes

☐ High/low blood pressure

☐ Varicose veins

☐ Heart condition

☐ Haemophilia

☐ Epilepsy

☐ Radiotherapy

Have you ever had an adverse reaction to hair removal?

☐ Yes

☐ No

Have you at any stage in your life had skin cancer, MRSA, herpes cold sores or skin infections?

☐ Yes

☐ No

Have you sun bathed in the last 24 hours? (optional)

☐ Yes

☐ No

Have you used any accutane products in the past 12 months?

☐ Yes

☐ No

I confirm that the information I have given is correct to the best of my knowledge. I will follow any aftercare advice given to me. (optional)

Please sign in the box above

Clear

Complete