Waxing/Tinting Consent Form

First Name:_____Last Name:_____

Address:_____ Zip:_____

Phone (C):_____Email:_____

Male:_____Female:_____Referred By:_____

Emergency Contact:_____Phone:_____

Relationship:_____

General Health Information

_____Pregnant _____Skin Cancer _____Psoriasis _____Seeing an Esthetician

_____Wear Contacts _____Eczema _____TMJ _____Seeing a Dermatologist

Are you currently using any of the following products: (**please circle**)

Accutane Antibiotics Benzoyl Peroxide Coritsone Retin-A SPF

E-mycin-T Glycolic Acid Salicylic Acid Sulfur Vitamins Prescriptions

Any food or cosmetic allergies? If so, please list?_____

_____

Any other concerns that are not listed here that should be noted? If yes, please describe:_____

_____

The above information is accurate and true to the best of my knowledge. I understand that there will be no diagnosis made. I take full responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that no session takes the place of medical attention and examination. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Signature: _____Date: _____