



Debra L. Bailey, M.D.

CLIENT CONSULTATION FOR HYDRAFACIAL TREATMENT

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

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____



HYDRAFACIAL®



SECTION 1: MEDICAL INFORMATION

- Do any of the following conditions relate to you?

Do you have any of the following allergies?

- Shellfish
- Aspirin
- Sulfur
- Preservatives
- Other (Please list): _____



YES	NO	Medical Information
		Accutane or other similar medication
		Autoimmune disease, HIV, lupus, hepatitis, scleroderma
		Blood thinners - Heparin, Coumadin, Warfarin, Daily Aspirin/NSAID or Vitamin E, etc.
		Breast feeding, pregnancy
		Cold sores or fever blisters without pre-medication
		Cortisone or steroid injections
		Cosmetic injections, fillers or implants, (i.e. Botox®, collagen) Within last 7 days?
		Enlarged or painful glands
		Facial waxing services w/in 7-14 days
		Inflammatory conditions
		Irregular, pigmented moles, warts or growths, unidentified facial growth or mark
		Keloids, pigmented scars, icepick scars, new scar tissue
		Laser procedures, chemical peels, dermabrasion, microdermabrasion
		Loose, thin, aged skin
		Lymphatic disorder, inflammation of lymph vessels, lymphedema
		Medications, Vitamins & Supplements, please list here:



YES	NO	Medical Information
		Recent surgical or dental procedure
		Rosacea telangiectasia/couperose
		Retin-A, Retinol
		Skin-lightening or bleaching agent
		Swollen or infected tonsils
		Thyroid conditions
		Type I diabetic
		Under medical care for an existing or suspected condition or disease
		Viral infection, influenza (Current)
		Other contraindication at discretion of skincare technician or medical practitioner: • 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.) _____



SECTION 2: CLIENT CONSENT FORM

(Initial each acknowledgement line below)

1. I acknowledge that I have not used Accutane or any medication for the same purpose during the last 12 months. _____ **(initial here)**
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. _____ **(initial here)**
3. I acknowledge that there is no guarantee that dark discoloration of skin will be reduced or fade. The appearance of pigmentation may improve or darken with successive treatments. I acknowledge the need for proper skin care home regimen. _____ **(initial here)**
4. I acknowledge that my skin might experience temporary irritation, tightness, or redness which usually dissipates within 72 hours depending on skin sensitivity. _____ **(initial here)**
5. I have disclosed my history of allergies above. _____ **(initial here)**
6. I acknowledge that if I am allergic to one or more of the ingredients in the products used, I may experience allergic reactions. _____ **(initial here)**



- 7. I acknowledge that if I fail to use a minimal sunscreen (SPF 30) and follow the direction for use, I am more susceptible to sunburn, sun damage & hyperpigmentation. I should avoid excessive sun exposure, especially between 10am - 2pm. _____ **(initial here)**
- 8. I acknowledge that this treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied. _____ **(initial here)**
- 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. _____ **(initial here)**
- 10. I acknowledge that I should avoid use of Retin-A type products for a period of time recommended by my physician and/or skincare practitioner during and following the treatment. _____ **(initial here)**
- 11. I acknowledge that I am not pregnant/lactating. _____ **(initial here)**
- 12. I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions. _____ **(initial here)**
- 13. I acknowledge that I have answered all questions truthfully and completely. _____ **(initial here)**
- 14. I release Edge Systems, Dr. Debra L. Bailey M.D., management and staff of High Tide Dermatology Center, LLC from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products. _____ **(initial here)**
- 15. I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes. My name will not be used to identify these photographs without my written approval. _____ **(initial here)**

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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.

Client Signature: _____ Date: _____

Operator Signature: _____ Date: _____