

A New Image Laser and Skin Care Clinic, Inc.
CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name _____ Today's Date _____

Date of Birth _____ Age _____ Occupation _____ Email _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone or Preferred Contact _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

Which of the following best describes your skin type? (Please circle one type number)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Brown, moderately pigmented skin
- VI Black skin

Do you regularly use tanning salons or sun bathe? _____ How often? _____

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No

If yes, for what: _____

Are you currently under the care of a dermatologist? Yes No

If yes, for what: _____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes No

Do you have any of the following medical conditions? (Please check all that apply)

- Cancer Diabetes High blood pressure Herpes Arthritis
- Frequent cold sores HIV/AIDS Keloid scarring Skin disease/Skin lesions
- Seizure disorder Hepatitis Hormone imbalance Thyroid imbalance
- Blood clotting abnormalities Any active infection

Do you have any other health problems or medical conditions? Please list: _____

CLIENT INFORMATION & MEDICAL HISTORY

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) Food Latex Aspirin Lidocaine
Hydrocortisone Hydroquinone or skin bleaching agents' Others:

MEDICATIONS

What oral medications are you presently taking? Birth control pills Hormones
Others (Please list): _____

Are you on any mood altering or anti-depression medication? _____

Have you ever used Accutane? Yes No, If yes, when did you last use it? _____

What topical medications or creams are you currently using? Retin-A® Others (Please list):

What herbal supplements do you use regularly? _____

HISTORY

Have you ever had laser hair removal? Yes No

Have you used any of the following hair removal methods in the past six weeks?

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No If yes, please describe: _____

For our female clients:

Are you pregnant or trying to become pregnant? Yes No Are you breastfeeding? Yes No

Are you using contraception? Yes No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date: _____

A New Image Laser and Skin Care Clinic, Inc.
CONSENT FORM for PHOTOFACIAL/SKIN REJUVENATION
and/or NON-ABLATIVE WRINKLE REDUCTION

Each paragraph requires initials preceding the paragraph before treatment commences.

I _____, consent to and authorize _____ to perform treatments on me. Light can be used effectively to destroy targets located in the skin with minimum damage to the surrounding tissues. Light is used to lighten, fade or remove photo-damaged skin in a nonablative manner, a procedure known as *photo rejuvenation*. Visible signs of photo damage include wrinkling, enlarged pores, coarse skin texture, and pigment alterations. _____

Photo-therapy, despite its high levels of efficacy and safety, is not free of side effects. Erythema (redness) and edema (swelling) of the treated area can occur but usually subsides within a few hours but can last up to seven days or longer. Irritation, itching, and/or a mild burning sensation or pain similar to sunburn may occur within 48 hours of treatment. _____

Pigmentary changes such as hyper pigmentation and hypo pigmentation of the skin in the treated areas can occasionally occur. Mostly it is transient, lasting up to six months, but in rare cases it can be permanent. Most cases of hypo- or hyper-pigmentation occur in people with darker skin or when the treated area has been exposed to sunlight before or after treatment. Occasionally these pigmentary changes occur despite appropriate protection from the sun. _____

Scarring, which can be hypertrophic or even keloid, can occur. Other known complications of this procedure include blisters, reddening; pinpoint pitted scars, bruising, superficial crusting, burns, pain, and infections. These side effects are usually temporary, lasting from five to ten days but can be permanent as well. _____

The skin at or near the treatment site may become fragile. If this happens, makeup should be avoided and the area should not be rubbed, as this might tear the skin. A blue-purple bruise may appear on the treated area, which might last from five to fifteen days. As the bruise fades, there may be rust-brown discoloration of this skin, which fades in one to three months or longer. _____

Additionally, there is a known and expected loss of hair in the treated areas. In a very small percent of people there is new hair growth in the surrounding areas being treated. _____

Even though appropriate measures are taken to reduce side effects, they cannot be completely eliminated in every case. I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. There may be other treatment options, such as injections, other types of lasers/light sources or peels. With this in mind, I am choosing this non-invasive treatment for vascular and/or pigment lesions and other indicated skin conditions.

_____ Eye damage can occur from the light and therefore protective eyewear must be worn during all phototherapy sessions. _____

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I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of scarring, and other side effects and complications such as hyper pigmentation, hypo pigmentation, and other skin textural changes. _____

I understand that this examination is not meant to replace the necessity for a complete dermatological examination. _____

Photographs: I give permission for my photographs to be used to help document my treatment course. Complete confidentiality will be maintained. _____

No guarantee, warranty, or assurance as been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over this time. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received. _____

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. _____

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment. _____

I release Goodman Enterprises, Inc. d/b/a A New Image Laser and Skin Care Clinic, Inc., medical staff, Cynthia Lee Goodman, and Kristine E Hembre D. O., specific technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This Consent Form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. _____

Note: All prices are subject to change without prior notice.

Client Signature _____ Date _____

(CLS), Aesthetician, Nurse
A New Image Laser and Skin Care Clinic

Date

A New Image Laser and Skin Care Clinic, Inc.

Skin Rejuvenation, Rosacea & Veins, Hair Removal and Non-ablative wrinkle work after care form

POST TREATMENT INSTRUCTIONS

1. Immediately after the treatments, you should apply an ice pack, as there may be mild swelling. It is normal for the treated area to feel like sunburn for a few hours. You should use a cold compress if needed. Avoid any trauma to the skin for up to 2-5 days, such as bathing with very hot water, strenuous exercise, or massage. _____
2. Avoid picking or scratching the treated skin to achieve your best results. If any crusting, apply antibiotic cream. Some physicians recommend aloe Vera gel or some other after sunburn treatment such as Desitin. Darker pigmented people may have more discomfort than lighter skin people and may require the aloe Vera gel or an antibiotic ointment longer. Follow instructions as specified by your laser professional. _____
3. Makeup may be used after the treatment has quit swelling unless there is epidermal bleeding. It is recommended to use new makeup to reduce the possibility of infection. Keep the area moist. Any moisturizer without alpha-hydroxy acids will work. _____
4. You may shower after the laser treatments in tepid water. The treated area may be washed gently with a mild soap. Skin should be patted dry and NOT rubbed. _____
5. You will experience redness and bruising from five to fourteen days at the treatment. Avoid direct sun exposure and tanning beds for 1-2 months and throughout the course of the treatment so as to reduce the chance of dark or light spots. Use sunscreen SPF 25 or higher at all times throughout the treatment when going outside. _____
6. Avoid tweezing, waxing, bleaching or chemical peels during the course of the treatment. Do not use any irritants such as Retin-A, Benzoyl Peroxide or astringents. _____
7. If work on the leg has been done, wear compression stockings for 48 hours and then during the day while on feet for up to two weeks. _____
8. Call "A New Image Laser & Skin Care Clinic, Inc." at (719) 592-1576 with any questions or concerns you may have after the treatment. _____

Client Signature

Date

(CLS), Aesthetician, Nurse
A New Image Laser and Skin Care Clinic, Inc.

Date