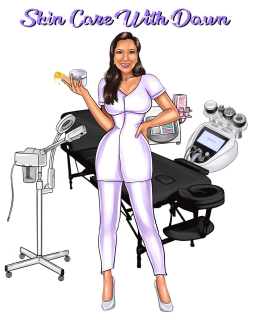
Intimate Skin Lightening Intake Form



General Information

Name | Date of Birth

Address

City | State | Zip Code

Phone # | Email

Occupation

Emergency Contact Name | Phone #

Would you like to be added to our email list for specials and discounts? Yes ☐ No ☐

How did you hear about us?

Medical History

Please check all that apply:

- ☐ Anaphylaxis
- ☐ Autoimmune Disease
- ☐ Blisters
- ☐ Bromhidrosis
- ☐ Cardiac Disorder
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Communicable Disease
- ☐ Diabetes
- ☐ HIV/AIDS
- ☐ HPV
- ☐ Hyperhidrosis
- ☐ Keloids
- ☐ Skin Cancer
- ☐ Skin Disease
- ☐ Sunburn
- ☐ Warts
- ☐ Other: _____

Treatment Area

Please check all that apply:

- ☐ Lower Labia
- ☐ Anal
- ☐ Inner Thighs
- ☐ Underarms
- ☐ Other: _____

Do you have any other medical conditions that we should know about? Yes ☐ No ☐

If yes, please list:

Are you currently taking any medications (including but not limited to blood thinners)? Yes ☐ No ☐

If yes, please list:

Do you have any allergies? Yes ☐ No ☐

If yes, please explain:

Have you had any surgeries within the past 6 months? Yes ☐ No ☐

If yes, please explain:

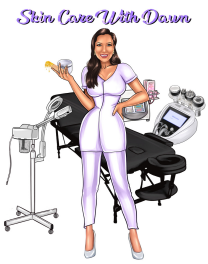
Are you currently using Accutane, Retinol, AHAs or BHAs? Yes ☐ No ☐

If yes, when:

(Female clients) Are you currently pregnant or nursing? Yes ☐ No ☐

When was the first day of your last menstrual cycle?

Are you currently under the influence of alcohol or drugs? Yes ☐ No ☐



Intimate Skin Lightening Liability Waiver

Intimate area lightening is a process of bleaching hyperpigmented (darker) skin to create an even skin tone. Please read and initial the statements below:

_____I acknowledge that the results of skin lightening vary and that no guarantees of specific results are offered or implied.

_____I understand that if I experience any pain or discomfort during any session I will immediately inform the practitioner so that the treatment may be adjusted or terminated.

_____I understand that intimate skin lightening should not be performed under certain medical conditions, including, but not limited to active herpes simplex outbreak, active HPV infection, diabetes, autoimmune diseases, history of keloids, warts, use or retinol, retinoids, Accutane, other transmittable diseases, irritated, raw, or broken skin, yeast infections, or if I am currently undergoing chemotherapy or other radioactive therapies.

_____I affirm that I have stated all my known medical conditions and answered all questions honestly.

_____ I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

_____ I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

_____ I understand that after the treatment, the skin may appear pink or red, and/or feel irritated.

_____ I understand that risks associated with skin lightening treatment include, but are not limited to an allergic reaction, reactivation of herpes simplex virus outbreak, blisters, burning, redness, irritation, and/or scarring.

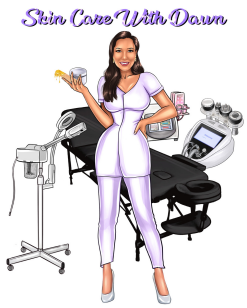
_____I understand that Skin Care With Dawn will not refund or credit any amount of money because of my unhappiness with my final results.

_____ I agree to hold Skin Care With Dawn and all employees, providers, medical directors, officers, directors, owners, and associates or authorized representatives harmless from any liability involved in the use of this treatment.

By signing below, I certify that I have read this entire document and that I agree to all its provisions. I certify that I have had the opportunity to ask questions my questions regarding the procedure have been answered satisfactorily. I fully understand the treatment conditions, the procedure, and possible side effects and I accept the risks. I hereby give my consent and authorization and release this establishment and its agents from any and all liability associated with the procedure.

_____	_____	_____
Name Printed	**Signature**	**Date**

Intimate Skin Lightening Pre and Postcare Instructions



Pre-Care

- Two days prior to treatment, discontinue using any topical medications. If in doubt about using any product, please discontinue it and discuss it with your esthetician at your appointment.
- If you have a history of herpes simplex virus (cold sores or fever blisters), in rare instances a reactivation of this condition could occur after treatment. Please inform your physician so that an anti-viral medication can be prescribed before the treatment. Otherwise, book the service once the affected area clears up.

Post-Care

- Wearing non-restrictive, loose-fitting garments to your appointment is recommended to avoid product transferring or rubbing on the treated areas.
- During the first 5 days post-treatment, care should be taken to prevent trauma to the treated site: avoid scrubs, luffas, washcloths, or anything abrasive. Any mechanical or thermal damage to the area must be avoided.
- Avoid anything that produces heat in the skin for five days. This includes but is not limited to hot baths, steam rooms, saunas, hot showers, UV exposure, and/or hot tubs.
- Avoid the gym for 24-48 hours.
- Cleanse the skin the following morning post-treatment with a gentle cleanser. The skin should be kept clean (cleanse twice a day) to avoid contamination or infection.