

"GentleLase" and "Varia" LASER HAIR REMOVAL QUESTIONNAIRE FORM

NAME: _____ DATE: _____

What areas are you interested in treating? _____

Type of hair: Coarse Fine Dark Light

Drugs or medicines to which you are allergic:

Names of all medicines you are now taking including Over the Counter products:

Have you recently taken Accutane?

Do you have a history of keloids/ hypertrophic scars?

Have you had any previous laser treatments?

When? _____ How many? _____ How frequently? _____ Response? _____

Do you have any other illness or medical condition?

What is your current method of hair removal? Wax Shaving Tweezing Electrolysis

When did you last use this method?

How would you best describe your goal for this treatment?

- Complete removal of all hair
- Removal of 75% of the hair
- Removal of 50% of the hair
- Anything would be an improvement

Skin type: _____

Endocrine Function: _____

Discussion of how laser works

- Type of laser
- History of laser
- FDA clearance

Discussion of Pre-procedure preparation

- Limit sun exposure
- Termination of other treatment
- Shave area one week before treatment
- Use and application of topical anesthetic

Discussion of Risks

- Scarring
- Hypo pigmentation
- Hyper pigmentation
- Possible stimulation of hair growth
- Incomplete hair removal

Discussion of Treatment

- How treatment feels
- How long treatment takes
- Provider of treatment

Discussion of aftercare

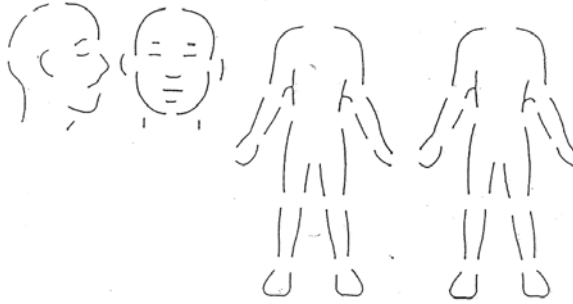
- Number of treatments expected
- What to expect after treatment
- How to treat: Pain? Swelling
- Average number of treatments for area
- Waiting period between treatments

Discussion of alternative treatments

- Electrology
- Bleach
- Wax, shave etc.

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Estheticians Notes: _____

AREA TO BE TREATED



*Areas to be treated: _____

Cost Per Treatment: #1 ___ #2 ___ #3 ___ #4 ___ #5 ___ #6 ___ #7+ ___

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Please note: In the event that a patient requests additional areas to be treated, the cost of treatment will result in additional charges.

** This treatment quote is valid for treatments started by _____ and completed by: _____. Prices are subject to change without prior notice.

Payment:

Cosmetic procedures are payable in full at the time treatment is rendered. We accept cash, checks, MasterCard and Visa for payment.

Appointment Policy

Patient must provide 24 hours advance notice in the event of cancellation of a scheduled appointment.

AUTHORIZED SIGNATURE/DATE

PATIENT SIGNATURE OR RECEIPT/DATE

(Patient signature is verification that the information provided on this form is accurate. This is not a consent or obligation for treatment.)

Please note that APD will honor the cost for treatment as stated above for a period of (30) days from the date of this consultation.