



Medical History and Consent

Full Name: _____ Date: _____

Email: _____ Phone: (____) _____

Address: _____

How were you referred to Allure YYC? _____

Current Medications (please print) _____

Have you taken **ACUTANE** within the last year? _____

Allergies (please list) _____

PLEASE READ CAREFULLY – Have you had, or do you currently have any of the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Botox Treatments |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Injectable Fillers |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Chemical Peels |
| <input type="checkbox"/> Dermatitis / Eczema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Glycolic Acid |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV / Aids | <input type="checkbox"/> Laser Resurfacing |
| <input type="checkbox"/> Latex Sensitivity | <input type="checkbox"/> Keloid Scars | <input type="checkbox"/> Pregnant / Nursing |
| <input type="checkbox"/> Tattoo / Permanent makeup | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Iron Deficient / Anemic | <input type="checkbox"/> Problems with Healing | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Plasma Pen Treatment | <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Hypo / Hyper Pigmentation | | |

**If you suffer from any of the above, it is important that you notify your technician so that they can take the necessary precautions to ensure you receive the best treatment and avoid any risks to your health*

PLEASE READ CAREFULLY AND INITIAL WHERE INDICATED – Ensure all points below have been discussed with the technician at Allure YYC. You are signing to state that you understand and accept these terms.

- I acknowledge that any information contributed by me is true, to the best of my knowledge and that the present condition of the area that has been treated or will be treated is stated on this record. I fully understand that Allure Esthetics only provides beauty services; there is no medical treatment involved. Plasma Pen treatment is a art – not a exact science – and cannot guarantee a exact shrinkage result due to the skin elasticity and individual healing process (Initial Her)



2. I understand that I may be required to return for additional treatment before the overall treatment is deemed complete. The payment for any additional work (if applicable), will be agreed prior to the treatment commencing. Depending upon area of treatment, additional treatments cannot be preformed until after 6-8 weeks after the initial treatment date. This is in order to allow the initially treated area to fully heal (Initial Here) _____
3. I realize that with any beauty service there may be certain risks, which must be understood, I will be fully responsible for any and all results, which may arise from these beauty services. I do hereby agree to hold Allure Esthetics free from any and all claims or suits for damage, for injuries or complications resulting from any beauty services provided by Allure Esthetics. I understand that any spot removals/skin revision work preformed could result in minor scarring and or loos or gain of natural skin pigment. (Initial Here) _____
4. The skin type of every client is different, and the healing process may lead to some discolouration of the skin. (Microdermabrasion or skin rejuvenation) may be advised, after the healing process is complete. (Initial Here) _____
5. I grand permission for the use of photographs, or electronic media images as identified, in any presentation of all kinds (Initial Here) _____
6. I have received pre and post procedure instructions with the care kit and will strictly adhere to them. I understand that failure to do so may jeopardize my chances for a successful procedure outcome. (Initial Here) _____
7. I understand the importance of my acute and complete medical history. I understand that withholding any medical information may be detrimental to my health and safety during and after the procedure. I understand that is there is any change in my medical history it is my responsibility to inform the technician. (Initial Here) _____
8. I am aware that the skin altering procedure such as Laser treatment, plastic surgery, implants, injectables and weight gain or loss may alter the treatment (Initial Here) _____

I, the client, agree with all the points listed and discussed, and wish to proceed as recorded. I participated fully in the decision for the selected area or areas intended for my Plasma Pen Treatment. I certify that I have fully read and initialed the above paragraphs. I have had it explained to my understanding therefore I consent to this procedure. I accept full responsibility for the decision to receive this treatment.

Client's Full Name (PRINTED): _____

Client's Signature: _____ Date (MM/DD/YYYY): _____

Treatment Agreement

I, the trained technician at Allure Esthetics, confirm I have checked all paperwork including consent forms and medical history. I have discussed all procedure points with the client and they understand all elements of the plasma pen treatment. Aftercare advice has been verbally presented to the client and written instructions will be provided.



Technician Signature: _____

Date: _____