ORTHOMED CLINIC AND SUPPLY

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COSMETIC TREATMENT
CLIENT INFORMATION PACKAGE

Date:_____

Title: [] Mr. [] Mrs. [] Miss. [] Ms. Gender: []M []F

Full Name_____ **Date of Birth**:_____
day / month /year

Address: _____City:_____

Postal Code_____ Phone: Home: (____)_____ Mobile: (____)_____

PLEASE CHECK SYMPTOMS/DISEASES

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

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

Have you ever had an allergic reaction to any of the following? []Food []Latex []Aspirin []Lidocaine []Hydrocortisone
[] Hydroquinone or skin bleaching agents []Others: _____

MEDICATIONS

What oral medications are you presently taking? []Birth control pills []Hormones []Others: _____
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: _____

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: _____

<u>For our female clients:</u>

Are you pregnant or trying to become pregnant?	[]Yes	[]No
Are you breastfeeding?	[]Yes	[]No
Are you using contraception?	[]Yes	[]No

Consent to Facial Treatment

I, authorize Orthomed Clinic and Supply and its practitioners/stuff members to facial, deep cleansing, exfoliating procedure. I understand that the procedure is purely elective. Treatment sites: face, neck, shoulders, back, chest. I understand that the procedure might involve physical/mechanical extraction, squeezing of the skin, electocoagulation, puncture of the skin via sterile needle. Serious complications are extremely rare, but possible. Common side effects include temporary redness (up to 2 days), irritation, crusting, bruising, scabbing, swelling. Other potential risks include blistering, crusting, itching, pain, bruising, infection, scabbing, scarring, bleeding, swelling, allergic reaction and failure to achieve the desired result. 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. 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 release Orthomed Clinic and Supply, medical staff, and 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. **<u>This is to confirm that I do NOT consent to reveal/release my file and all confidential information pertaining to my treatments and any related services to any third party.</u>**

CLIENT SIGNATURE_____ Date_____