

Skin Science, Inc.
Patient Information Sheet

Patient:

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: Female Male

Home: (_____) _____ Work: (_____) _____

Cell: (_____) _____ e-mail: _____

How were you referred:

Brazilia Web Site Skin Science Web Site S.D. Reader
 Walk-In Brazilia Staff (name) _____
 Friend/Family (name) _____ Other: _____

Emergency Contact:

Name: _____ Relationship: _____
Home: (_____) _____ Work: (_____) _____
Cell: (_____) _____ Other: (_____) _____

Appointment/Cancellation Policy:

Any cancellations should be made with 24 hours or more prior to the appointment date and time. Failure to do so, or a no-show at time of the appointment, will result in the full amount of the booked service being charged. If a service package has been purchased, breach of this policy will result in the deduction of one of the paid treatments. This policy remains in effect throughout the entire course of treatment and includes touch-up appointments.

By signing below, I declare that I have read and understand the Skin Science, Inc. Appointment/Cancellation Policy. I understand that I must contact Skin Science at 858-909-0911 with a minimum of 24 hours notice of any cancellation or rescheduling of any appointment in order to avoid incurring a cancellation charge or deduction in package series.

Signature: _____ Date: _____

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MEDICAL HISTORY FORM

Name: _____ Date: _____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Do you have ANY current or chronic medical illnesses we should know about?
Please List: _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you currently under a doctor's care? If so, for what reason?
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you take/use ANY medications, herbal or natural supplements or topicals on a regular or daily basis?
Please List: _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have ANY allergies to medications, foods, latex or other substances?
Please List: _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> |

MEDICAL HISTORY

- | | Yes | No |
|--|--------------------------|--------------------------|
| 5. (For women) are you or could you be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. (For women) are menstrual period regular? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have a history of herpes I or II in the area to be treated? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have a history of keloid scarring? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you taken Accutane or anticoagulants in the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have any permanent make-up, implants or tattoos?
If yes, please list locations. _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had any unprotected sun exposure, use tanning creams or tanning beds in the last 4-6 weeks? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Which body area(s) or condition would you like to treat?
Please List: _____
_____ | | |

Signature: _____ Date: _____

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SKIN TYPING WORKSHEET

Client Name: _____ Date: _____

Score:		0	1	2	3	4
	What is your eye color?	Light blue or gray	Blue or green	Hazel, Light brown	Dark Brown	Brownish black
	What is the natural color of your hair?	Red, Sandy red	Blonde	Dark blonde, Chestnut, Brown	Dark brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns
	To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Tan dark brown quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always
Add above column for Total Score	Match your total score with the corresponding skin type.	Fitzpatrick Skin Type				
	0-7	I				
	8-16	II				
	17-25	III				
	26-30	IV				
	Over 30	V-VI				

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EXCLUSIONARY CRITERIA

Exclusionary criteria for light therapy include, but are not limited to:

- ☞ **Unprotected sun exposure or use of tanning beds or creams in areas to be treated.** This applies to all hand pieces except the LuxR and LuxRs, which are designed to treat all skin types, including tanned skin. Protected sun exposure means wearing protective clothing or the daily use of SPF-30 or greater sunscreen. Patient should be advised to discontinue tanning for four weeks prior to treatment, during treatment course, and 4-6 weeks after treatment. This will reduce the chances of skin color changes and development of new pigmented lesions.
- ☞ **Pregnancy.** There is no clinical evidence at this time of fetal harm from a light-based system, but the results of treatment may be erratic or unreliable due to fluctuations in hormonal levels, hair growth cycles and physiological conditions.
- ☞ **Menstrual dysfunction.** Patients with menstrual dysfunction or hyperandrogenism should be referred to an endocrinologist for evaluation and possible medical treatment. These patients tend to have hirsutism which may respond to medical treatment.
- ☞ **Use of mechanical epilation less than six weeks prior to treatment for patient seeking hair removal.** This includes plucking, waxing, tweezing, electrolysis, threading or sugaring. Patient should also refrain from these practices during the treatment course.
- ☞ **Allergies.** Confirm with patient any allergies to medications, latex, foods or other substances that may be used during the course of treatment.
- ☞ **History of seizures.** Flashing lights may trigger a seizure.
- ☞ **Medications.** Both prescription and non-prescription. Be sure to include herbal and natural remedies as some of these may cause photosensitivity. Patient should not be taking Accutane[®], anticoagulants or St. John's Wort. For patients taking a photosensitizing medication, perform a test spot 24 hours before treatment.
- ☞ **History of keloid or hypertrophic scar formation.** Although scarring is rare, picking or pulling off scabs or crusting can result in scarring. For this reason it is recommended to exclude from treatment patients with known tendency to form keloid or hypertrophic scars.
- ☞ **Active infections/Immunosuppression.** Active infections and immunosuppression compromise the healing ability of the body. Reschedule the patient when infection is cleared.
- ☞ **Open lesions.** Treatment should only be done on intact healthy skin, with the exception of acne infected skin.
- ☞ **Herpes I or II within the treatment area.** Patients should consult their primary care providers for medical evaluation and possible prophylaxis prior to treatment.
- ☞ **Tretinoin (Retin-A[®], Renova[®]).** Although tretinoin use in area to be treated is not absolutely contraindicated, it is known to make skin more sensitive and prone to exfoliation. Patient is better advised to discontinue the use of exfoliating creams and other exfoliating products two weeks prior to and during the entire treatment course.
- ☞ **Oral isotretinoin (Accutane[®]) within the preceding six months.** Accutane changes the underlying structure of the skin, which may cause unreliable results. It may also cause increased sensitivity to light.

Print Name: _____

Date: _____

Signature: _____

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CONSENT TO PULSED LIGHT TREATMENT

I authorize any associates or assistants of Dr. Hochman and/or Skin Science, Inc. to perform pulsed light treatment on me. I understand that this procedure is purely elective.

I understand the following:

- ☞ Serious complications are rare but possible.
- ☞ Common side effects include temporary redness and mild "sunburn" like effects that may last anywhere from a few hours to several days.
- ☞ Treatment of benign pigmented lesions and vascular lesions cannot be accomplished without producing some epidermal damage, and this may take 2-4 weeks to resolve.
- ☞ Pigment changes (light or dark spots on the skin) lasting 1-6 months or longer may occur. In addition, freckles may lighten and may temporarily or permanently disappear in treated areas.
- ☞ There is a likelihood of coincidental hair removal when treating pigmented or vascular lesions in hair-bearing areas.
- ☞ Other potential risks include blistering, crusting, itching, pain, bruising, skin whitening, burns, infection, scabbing, scarring, swelling and failure to achieve desired result.
- ☞ I understand that sun exposure or use of tanning lamps or self-tanning creams and not adhering to the post-care instructions provided to me may increase my chance of complications.

☞ I understand the importance of having an accurate diagnosis of pigmented lesions (brown spots on the skin) by a physician prior to treatment, as treatment of an undiagnosed skin cancer may delay proper medical care.

Initial

☞ I understand that the **AVERAGE** number of treatments needed for hair removal are 7-12. I further understand that this number is an estimated number of treatments **ONLY** and actual number of treatments can vary depending on various factors including, but not limited to, skin tone, hair color & coarseness, hormones, medications, frequency of treatments, etc.

Initial

I consent to photographs being taken to evaluate treatment of effectiveness, for medical education, training, professional publications or sales purposes. No photographs revealing my identity will be used without my consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

Pre- and post-treatment instructions have been discussed with me. I have read and understand the attached Exclusionary Criteria. This procedure as well as alternative treatment options and the potential benefits and risks of each have been explained to my satisfaction. I have had all my questions answered.

I FREELY CONSENT TO THE PROPOSED TREATMENT.

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR PULSED LIGHT TREATMENTS ARE NON-REFUNDABLE.

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR PULSED LIGHT TREATMENT AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Name (please print)

Signature

Date

Parent/Legal Guardian

Signature

Date

Witness/Representative

Signature

Date

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OFFICE USE ONLY

Receptionist: _____

Scheduled Appt Date: _____

Topical Anesthetic Consent

Topical anesthetic is used for the management of discomfort associated with Laser Hair Removal, Photorejuvenation and other elective cosmetic procedures. The medication used at Skin Science is a compounded topical application of Lidocaine 6% and Tetracaine 6% in a cream base.

I understand that approximately one hour prior to the procedure the medication is rubbed into the skin at the site of the procedure (bikini area is covered with an occlusive dressing (plastic wrap) immediately after application).

I understand that the possible side effects include local irritation at the site of administration. I may also experience a feeling of warmth or coolness; this is considered normal and does not indicate an allergic reaction. Side effects that may subside during treatment include skin paleness, loss of feeling, itching, redness and/or swelling at the treatment site.

I understand that this product contains soy and egg protein and if I am sensitive to soy or egg products I should not use this product. I also understand that I should not use this medication if I am allergic to Lidocaine or any of the "caines."

I understand that in general, topical anesthetics are not to be used by anyone with a history of seizures, liver disease, or anyone who is nursing or pregnant.

I agree to disclose a full and accurate personal medical history to include any and all information regarding medical conditions and my use of medications: including herbs, vitamins, and any other supplements. I understand that failure to do so may affect my treatment outcome and increase the possibility of complications.

I am aware that the medication blocks pain and feeling to the skin and I must therefore be careful not to injure the treated skin by scratching, rubbing or coming in contact with extreme heat or cold.

I have been asked at this time if I have any questions about the topical anesthetic and I do not. I understand the risks and request that the topical anesthetic be used prior to treatment.

Printed Name: _____ Date: _____

Patient Signature: _____

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POST-TREATMENT INSTRUCTIONS

General

- ☞ A mild sunburn-like sensation is expected. This usually lasts 2-24 hours but can persist for up to 72 hours. Mild swelling and/or tenderness may accompany this, but it usually resolves in 2-3 days.
- ☞ Apply ice or cold packs to treatment area for 10-15 minutes every hour for the next four hours, as needed. An oral, non-steroidal anti-inflammatory, such as acetaminophen may be taken to reduce discomfort. Use according to manufacturer's recommendations.
- ☞ In some cases, prolonged redness or blistering may occur. An antibiotic ointment may be applied to the affected areas twice a day until healed.
- ☞ Bathe or shower as usual. Treated areas may be temperature-sensitive. Cool showers or baths will offer relief. Avoid aggressive scrubbing and use of exfoliants, scrub brushes and loofah sponges until the treatment area has returned to its pre-treatment condition.
- ☞ Until redness is completely resolved, avoid all of the following:
 - Applying cosmetics to the treated areas.
 - Swimming, especially in pools with chemicals, such as chlorine.
 - Hot tubs or Jacuzzis.
 - Activities that cause excessive perspiration.
 - Sun exposure to treated areas. Apply SPF-30 or greater sunscreen to prevent development of new pigmented lesions.

FOR HAIR REMOVAL

- ☞ Appearance of hair growth or stubble will continue for 7-30 days post-treatment. This is not new hair growth, but the treated hairs being expelled from the skin.
- ☞ In patients with facial hirsutism who have been diagnosed with polycystic ovarian syndrome and presenting ovarian hyperandrogenism, there is a risk of paradoxical effect resulting from activation of dormant hair follicles in untreated areas close to hirsute-treated areas.

FOR PIGMENTED LESION TREATMENT

- ☞ The lesion may initially look raised and/or darker with a reddened perimeter.
- ☞ The lesion will gradually turn darker over the next 24-48 hours. It may turn dark brown or even black.
- ☞ The lesion will progress to scabs/crusting and will start flaking off in 7-14 days. Do not pick, scratch or remove scabs.
- ☞ The lesion is usually healed in 21-30 days. It will continue to fade over the next 6-8 weeks.

FOR VASCULAR LESIONS

- ☞ The vessels may undergo immediate graying or blanching, or they may exhibit a slight purple or red coloring. The vessels will fully or partially fade in about 10-14 days. Do not pick, scratch or remove scabs.
- ☞ Repeat treatments may be performed every 7-10 days if skin is fully recovered.

I have read and understood the Hair Removal Aftercare Instructions.

Name: _____ Date: _____

Signature: _____

If you have any questions or concerns, please contact us immediately.
Skin Science, Inc. 858-909-0911.

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HAIR REMOVAL

AREA	\$/SINGLE TREATMENT*	PKG OF 5 (SAVE 20%+)	3 OR MORE PKGS OF 5 (SAVE 30%)
ABDOMEN M	\$240	\$960 (\$192)	\$840 (\$168)
ABDOMEN F	\$180	\$720 (\$144)	\$630 (\$126)
ARMS (upper or lower)	\$180	\$720 (\$144)	\$630 (\$126)
BACK (full)	\$480	\$1920 (\$384)	\$1680 (\$336)
BIKINI BASIC	\$150	\$600 (\$120)	\$525 (\$105)
BIKINI PLAYBOY	\$210	\$800 (\$160)	\$735 (\$147)
BIKINI BRAZILIAN	\$240	\$900 (\$180)	\$840 (\$168)
BUTTOCKS	\$210	\$800 (\$160)	\$735 (\$147)
CHEEKS/SIDEBURNS	\$100	\$400 (\$80)	\$350 (\$70)
CHEST	\$270	\$1080 (\$216)	\$945 (\$189)
CHIN	\$100	\$400 (\$80)	\$350 (\$70)
EARS	\$150	\$600 (\$120)	\$525 (\$105)
FEET	\$150	\$600 (\$120)	\$525 (\$105)
HANDS	\$150	\$600 (\$120)	\$525 (\$105)
HAPPY TRAIL	\$100	\$400 (\$80)	\$350 (\$70)
LEGS (upper or lower)	\$360	\$1400 (\$280)	\$1260 (\$252)
LEGS (full)	\$600	\$2400 (\$480)	\$2100 (\$420)
LIP	\$100	\$400 (\$80)	\$350 (\$70)
NECK (back of)	\$120	\$480 (\$96)	\$420 (\$84)
NECK (front of)	\$150	\$600 (\$120)	\$525 (\$105)
NIPPLES	\$100	\$400 (\$80)	\$350 (\$70)
SHOULDERS	\$270	\$1080 (\$216)	\$945 (\$189)
UNDERARMS	\$105	\$400 (\$80)	\$367.50 (\$73.50)

*20% off when treating 3 different areas per visit

Treatment Intervals for Hair Removal

Face 2-4 weeks
 Bikini, Underarms, Arms 4-6 weeks
 Back, Chest, Abdomen, Legs 8-10 weeks

PHOTOREJUVENATION

AREA	\$/SINGLE TREATMENT*	PKG OF 3
FACE	\$350	\$900
NECK	\$200	\$500
CHEST	\$400	\$950
ARMS (upper or lower)	\$400	\$950
HANDS	\$250	\$600

*20% off when treating 3 different areas per visit

BOTOX \$9 per unit

JUVEDERM –U.P. \$500 per syringe (0.8cc)

Payments for treatments are non-refundable. Any discounts (coupons/promotions/etc.), IF APPLICABLE, may be valid for only one treatment. Prices are subject to change without notice.

Print Name: _____

Date: _____

Signature: _____



Brazilia Skin Care

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www.myskinscience.com