Endocrinology

SKIN ANALYSIS
FACIAL TREATMENT

GENERAL INFORMATION

Client Full Name: | Date of Birth:

Email Address: | Phone No:

SKIN TYPE ASSESSMENT

How would you describe your skin type?

☐ Normal ☐ Oily ☐ Dry ☐ Sensitive ☐ Combination

SUN EXPOSURE

How often are you exposed to the sun?

☐ Rarely ☐ Occasionally ☐ Frequently ☐ Daily

Do you use sunscreen regularly? Yes / No

SKINCARE ROUTINE

What is your current skincare routine? (Please list products used)

Cleanser ..... Toner .....

Serum ..... Moisturizer .....

Sunscreen ..... Other.....

How often do you exfoliate?

Do you use any acne treatments? Yes / No

If yes, please specify:

Do you use retinol or any other prescription skincare products? Yes / No

If yes, please specify:

SKIN CONCERNS

What are your primary skin concerns? (Please check all that apply):

☐ Acne ☐ Hyperpigmentation ☐ Sensitivity

☐ Blackheads/Whiteheads ☐ Redness/Rosacea ☐ Dark Circles

☐ Large Pores ☐ Dryness/Dehydration ☐ Sagging Skin

☐ Fine Lines/Wrinkles ☐ Oiliness ☐ Dullness

☐ Other .....

ADDITIONAL INFORMATION

Have you had any previous facial treatments? Yes / No

If yes, please specify:

Have you experienced any adverse reactions to skincare products or treatments? Yes / No

If yes, please specify:

GOALS AND EXPECTATIONS

What are your goals for your skin?

Are there any specific treatments you are interested in?

Do you have any upcoming events or special occasions? Yes / No

If yes, please specify:

Continued on next page

Endocrinology

SKIN ANALYSIS
FACIAL TREATMENT

GENERAL INFORMATION

Client Full Name:

Date of Birth: | Gender:

Street Address:

City:

Zip Code: | State:

Email Address: | Phone No:

EMERGENCY CONTACT

Name: | Phone No:

How did you hear about us?

I understand that the information provided in this intake form will be used to assess my suitability for facial treatment and to provide appropriate care. I certify that all information provided is accurate and complete to the best of my knowledge.

I consent to the facial treatment and agree to follow any recommendations provided by the skincare professional. I understand that results may vary, and there are potential risks and side effects associated with the treatment.

CLIENT NAME - PRINTED

CLIENT - SIGNATURE

DATE

doctoriglesiasmiamilakes@gmail.com 305-381-5301 @LysetteIglesiasMD

Endocrinology

INTAKE FORM
FACIAL TREATMENT

MEDICAL HISTORY

Are you currently under the care of a dermatologist? Yes / No
If yes, please specify:

Do you have any known allergies? Yes / No
If yes, please list:

Are you currently taking any medications? Yes / No
If yes, please specify:

Have you undergone any cosmetic procedures in the past 6 months? Yes / No
If yes, please specify:

Do you have any metal implants including dental braces? Yes / No
If yes, please specify:

Do you smoke? Yes / No Do you consume alcohol? Yes / No

How much water do you drink daily? How many hours of sleep do you get on average?

Please check if you have or have had any of the following medical conditions:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Epilepsy
- ☐ Asthma
- ☐ Autoimmue diseases
- ☐ Bleeding Disorders
- ☐ Thyroid Disorders
- ☐ Neuromuscular Disorders
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Keloid Scars
- ☐ Recurrent cold sores
- ☐ Herpes Simplex Virus
- ☐ Cancer (Specify type) .....
- ☐ Other medical conditions .....

Please check if you are allergic to any of the following:

- ☐ Fragrances
- ☐ Essential Oils
- ☐ Latex
- ☐ Adhesive Tapes
- ☐ Metals (Specify): .....
- ☐ Skincare Products (Specify type): .....
- ☐ Other (Specify): .....

CLIENT NAME - PRINTED CLIENT - SIGNATURE DATE

Continued on next page

Endocrinology

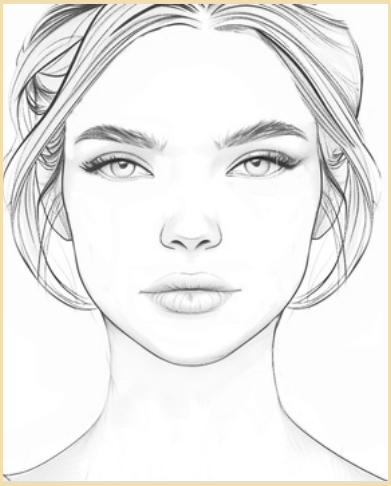
INTAKE FORM

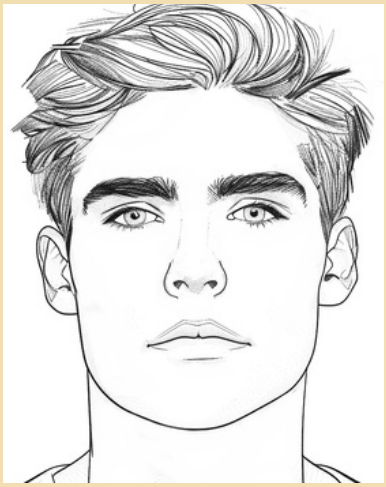
FACIAL TREATMENT

LAST BOTOX AND FILLER TREATMENT

Have you undergone Botox and/or filler treatments in the last 6 months? If yes, please provide detailsabout the last treatment, including the treated areas and products used (if known):

- ☐
- ☐
- ☐
- ☐
- ☐





Mark Treated Areas with an X

I understand that the information provided in this intake form will be used to assess my suitability for facial treatment and to provide appropriate care. I certify that all information provided is accurate and complete to the best of my knowledge.

I consent to the facial treatment and agree to follow any recommendations provided by the skincare professional. I understand that results may vary, and there are potential risks and side effects associated with the treatment.

CONSENT AND AGREEMENT

I consent to the taking of photographs of my face for personal use. These photographs will be used solely to document my treatment progress and for before-and-after comparisons. I understand that these photographs will be kept confidential and will not be shared or used for any other purposes without my explicit consent.

I have read and understand the information provided in this consent form. I have had the opportunity to ask questions and have received satisfactory answers. I consent to undergo Botox treatment with full knowledge of the potential risks, complications, and side effects.

CLIENT NAME - PRINTED

CLIENT - SIGNATURE

DATE

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CONSENT FORM
FACIAL TREATMENT

I, ... [Client's Full Name], grant my consent for facial treatment at [Clinic/Medspa/Salon Name], referred to as "the Provider." I understand that facial treatments are cosmetic procedures designed to cleanse, exfoliate, and revitalize the skin to enhance its appearance and overall health.

Details of the Procedure: The purpose of the facial treatment is to cleanse, exfoliate, hydrate, and nourish the skin, targeting specific concerns such as acne, blackheads, dryness, signs of aging, or uneven skin tone. The treatment may include various techniques like cleansing, steaming, extraction, exfoliation, massage, mask application, and moisturization, customized to my skin type and concerns, whether performed manually or with specialized facial machines.

Expected Results: I understand that the results of the facial treatment may vary depending on individual factors such as skin type, condition, and lifestyle habits. Immediate effects may include improved skin texture, hydration, and a refreshed appearance. Achieving optimal results often requires multiple sessions and ongoing maintenance treatments.

Potential Side Effects and Risks: I acknowledge that facial treatments may lead to temporary side effects such as redness, swelling, or irritation, as well as sensitivity or allergic reactions to the products used. Skin purging or breakouts may occur following extraction, and although rare, severe adverse reactions are possible.

Pregnancy and Breastfeeding Status: I confirm that I am not currently pregnant or breastfeeding. I understand that certain facial treatments may not be advisable during pregnancy or breastfeeding, and I have informed my facial provider of my current status. By acknowledging this, I take full responsibility for disclosing any such conditions to ensure the safety and suitability of the facial treatment provided.

Post-Treatment Care: I agree to adhere to the post-treatment care instructions provided by the provider, having been thoroughly explained these instructions, and commit to following them diligently.

CONSENT AND AGREEMENT

I consent to the taking of photographs of my face for personal use. These photographs will be used solely to document my treatment progress and for before-and-after comparisons. I understand that these photographs will be kept confidential and will not be shared or used for any other purposes without my explicit consent.

I have read and understand the information provided in this consent form. I have had the opportunity to ask questions and have received satisfactory answers. I consent to undergo Botox treatment with full knowledge of the potential risks, complications, and side effects.

CLIENT NAME - PRINTED ..... CLIENT - SIGNATURE ..... DATE .....

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FACIAL

DO'S

- Stick to any post-facial skincare regimen recommended by your esthetician to maintain results.
- Apply sunscreen if going out to shield your skin from harmful UV rays.
- Be Gentle with your skin, and avoid harsh scrubbing or rubbing.
- Moisturize with a gentle, non-comedogenic moisturizer to keep skin supple and hydrated.

DON'TS

- Avoid Sun Exposure as your skin may be more sensitive after a facial.
- Avoid using heavy or irritating skincare products immediately after a facial.
- Refrain from touching or picking at your face to prevent irritation or infection.
- Resist the urge to over-exfoliate or use harsh exfoliants, as this can irritate freshly treated skin.
- Avoid strenuous exercise or activities that may cause excessive sweating,
- Avoid Makeup immediately after the facial to allow your skin to recover.
- Avoid facial and laser treatments and cosmetic injections after your facial till your skin is fully healed.

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CANCELLATION POLICY

In order to ensure the provision of high quality care in a reasonable time, an appointment and cancellation policy has been established. Since appointments are in high demand, canceling in advance allows us to assign the time to other clients who need immediate attention. This regulation contributes to improving the availability of appointments for all our clients. During your appointment booking, you will be asked to make a deposit of __$25.00__, which will be used as credit towards your scheduled treatments. We understand that situations may arise that require you to cancel or reschedule your appointment. To avoid problems, we ask that you give us at least 24 hours' notice. In these cases, your deposit will be refunded or applied to a later appointment. However, if you give less than 24 hours' notice, a cancellation fee of _$25.00__ will apply. Please note that if you arrive more than _15_ minutes late for your appointment, you will be considered a no-show and a cancellation fee will apply. We are available to answer any questions or concerns that may arise regarding our cancellation policy.

To establish contact, use our email address indicated below, avoid leaving a message on the recorder, because at the volume of the calls, it will not be heard.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by its terms. I agree to pay the cancellation fee if I miss an appointment.

CLIENT NAME - PRINTED

CLIENT - SIGNATURE

DATE

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Endocrinology

RELEASE FORM
PHOTO & VIDEO

I_____,hereby grantanda uthorize___Lysette Iglesias MD_. The right is granted to capture, modify, edit, reproduce, display, publish, distribute and use any photograph, video and/or audio recording taken for lawful promotional purposes. These materials may include, but are not limited to, newspapers, brochures, posters, advertisements, press kits, websites, social media platforms and other forms of print and digital communication. This authorization is granted without expecting any payment or other form of consideration.

This authorization is valid indefinitely and covers all languages, media, formats and markets, whether currently known or discovered in the future.

I voluntarily waive any rights to royalties or other compensation arising from or related to the use of these photographs or recordings.

I acknowledge and agree that materials produced under this agreement will become the property of _____Lysette Iglesias MD___ and will not be returned to me.

I hereby release and release _____Lysette Iglesias _____ from any liability, claim or legal action that may arise, including those made by me, my heirs, representatives, executors, administrators or any other person acting on my behalf or on behalf of my estate.

By signing below, I certify that I have carefully read and understood the entirety of the above waiver agreement.

CLIENT NAME - PRINTED	CLIENT - SIGNATURE	DATE
PARENT/LEGAL GUARDIAN (IF APPLICABLE)	PARENT/LEGAL GUARDIAN SIGNATURE	DATE
WINTESS NAME	WITNESS SIGNATURE	DATE

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