## New-_circular_logo_for_web.jpgMandala Med-Spa and Yoga Shala L.L.C.

# Marguerite Barnett, M.D., P.A.

##  W axing Consent

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of first visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home/Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1) Have you ever been waxed before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What areas? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Any problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) Do you take or use any products that contain the following?

 Isotr--etinoin \_\_\_\_\_\_ Tetracycline \_\_\_\_\_\_ Retinoic Acid \_\_\_\_\_\_ AHA Glycolic Acid \_\_\_\_\_\_ Hydroquinone \_\_\_\_\_\_

4) Have you recently had any type of chemical or glycolic peel? \_\_\_\_\_\_ If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5) If chemical, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If glycolic, what percentage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6) Any recent surgery or dermabrasion? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7) Any skin cancer or removal of skin cancer? \_\_\_\_\_\_\_\_\_\_\_\_\_

8) Are you a hemophiliac? \_\_\_\_\_\_\_\_\_\_ 9) Are you pregnant? \_\_\_\_\_\_\_\_\_\_ 10) Are you on your menstrual cycle? \_\_\_\_\_\_\_\_

11) Are you on any medications, including birth control? If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12) Have you taken any blood thinners, aspirin or any anti-coagulating medication within the past 24 hours? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13) Do you have any moles, warts, abrasions, skin irritations or skin inflammations in the areas to be waxed? No \_\_\_\_\_\_\_\_\_\_\_

 If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14) Do you have any allergies? If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15) Have you been exposed to any tanning method in the past 24 hours? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16) How would you rate your sensitivity to pain? Low \_\_\_\_\_\_ Medium \_\_\_\_\_\_ High ­­\_\_\_\_\_\_\_

In an effort to make your waxing experience as comfortable as possible, please supply your wax technician with all necessary details in regard to past waxing procedures or health information not requested on this form.

**RELEASE FOR WAXING SERVICE:** *I understand that the waxing service I have requested involves the application of heated products that may cause an adverse reaction to my hair, skin or body on which the service is performed. I fully understand that this establishment and its agents may refuse to perform the treatment I have requested if I have answered “yes” to any of the above questions. I have read the Before & After procedures sheet, provided by the technician, and understand that failure to follow these instructions could result in an adverse reaction that may cause injury or damage to my skin. I hereby release this establishment, its agents, and suppliers from any and all damage or injury that may result from the treatment requested. I further confirm that I am over the age of 18 years old.*

**Print Name**  **Signature \_\_\_\_\_ \_**  **Date\_\_\_\_ \_\_\_\_**