New Skin TATTOO REMOVAL

PLEASE COMPLETE ALL INFORMATION

PERSONAL HISTORY

Client Name____**Today's Date**____

Sex__________ **Date of Birth**_________________________**Age**__________**Occupation**______________________________________

Home Address_____________________________________**City**_________________________ **State**________ **Zip**____________

Home Phone (   )______________________________ **Cell Phone (   )**____

Email____

Emergency Contact Name and Phone____

How did you hear about us? ____________________**How old is your tattoo?** ____

Is your tattoo professional or amateur?____

MEDICAL HISTORY

Are you currently under the care of a physician/dermatologist? ☐**Yes** ☐**No** If yes, explain:____
Have you ever had a reaction to previous laser treatment, heat treatment or radiation therapy? ☐**Yes** ☐**No**
If yes, for explain:____

Do you have any of the following medical conditions? (Please check all that apply)

☐Cancer ☐ Diabetes ☐ Herpes ☐ Arthritis ☐ Frequent Cold Sores ☐ HIV/AID ☐ Skin Disease/Skin Lesions ☐ Seizure

☐ Keloid Scarring ☐Disorder ☐Hepatitis ☐Blood Clotting Abnormalities ☐Any Active Infection ☐Hyperpigmentation ☐Hypopigmentation

Do you currently have a sunburn ☐ **Yes** ☐ **No** ☐ **OTHER MEDICAL CONDITIONS**____

☐ **No Known Medical Conditions**____

For our female clients:

Are you pregnant/trying to become pregnant? ☐**Yes** ☐**No** Are you breastfeeding? ☐**Yes** ☐ **No** Are you using oral contraception? ☐ **Yes** ☐ **No**

I will notify staff if I do become pregnant/start breastfeeding ____________ **Initials**

MEDICATION

What oral medications are you presently taking? Please List:____
Have you ever used Accutane (used for acne) ☐**Yes** ☐**No**, If yes, when did you last use it?____
What tropical medications or creams are you currently using? **Retin-A** Others Please List:____
Have you ever had an allergic reaction to any medication, or any other allergies?
Please List: ____

*I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures*______________ **Initials**

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DISCLOSURES

PATIENT CONSENT/ASSIGNMENT

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform New Skin of my current medical or health conditions and to update this history. A current medical history is essential for our physician to execute appropriate treatment procedures.

I, the undersigned, understand that I am financially responsible for all charges. I understand that insurance carriers do not cover these services.

Signature:____Date:___________________________

Parent/Guardian:____Date:___________________________

PRIVACY POLICY

I have received and/or read the (HIPAA) Notice of Privacy Practices. (Copies Available Upon Request)

Signature:____Date:___________________________

Parent/Guardian:____Date:___________________________

PHOTOGRAPH AUTHORIZATION & CONSENT

I, the undersigned, authorize New Skin Adult Tattoo Removal to take photographs of my tattoos before, during and after my treatments. My name will not be used unless I specifically agree that it may be used. I also understand that these photographs may be used for purposes including, but not limited to, educating future patients and in possible publications and promotions. I enter into this agreement willingly and hereby waive any right to compensation for such uses as New Skin Tattoo Removal may determine. ☐**REFUSE**

Signature:____Date:___________________________

Parent/Guardian:____Date:___________________________

Please initial each line

_____I understand that laser tattoo removal can take several treatments. The amount of treatment sessions varies. I also understand laser treatments fails to remove all pigment, especially from professional applied tattoos or deep amateur tattoos. It may not be effective on certain pigments such as red, blue, green and yellow. Hyper/Hypo pigmentation which may be potentially permanent and may make a white tattoo darker. (Depending on location, type of ink, length of time, etc.)

_____I know that I will be expected to wear protective eyewear during the procedure.

_____I am older then 18 years old, (or have my parent/guardian present)

_____I understand that there may be changes in the skin texture, permanent lightening or darkening of the skin, hair loss or thinning.

_____I am aware that I may experience bruising/blisters post treatment **(post-op instructions given)**

_____I am not allergic to red dye.

_____I am aware that there is a risk of scarring (in particular raised scars) despite proper laser treatments.

_____I understand that continued improvement can occur for several months after the treatment. (At times, you may be asked to skip a month, if determined by R.N.)

_____I understand that New Skin does not use topical anesthesia. (Additional information can be given upon request)

_____I understand that I will need to cancel / reschedule my appointments 24 hours in advance to avoid a of $25.

_____I have read and understand the rules New Skin Tattoo Removal has set forth. I agree to comply with ALL terms listed.

_____I understand that **NO absolute guarantee** of any kind has been made to me, by either the doctor or his/her staff regarding the procedure, the number of procedures or it's final outcome

_____Finally, I understand that even extremely remote and extremely rare possibilities (such as death or permanent disability-clearly the likelihood of these occurrences is very, very, very small) can occur with any medical procedure.

I have read & understand the guidelines/rules and expectations for tattoo removal.

Signature:____Date:___________________________

Parent/Guardian:____Date:___________________________

Nurse Practitioner:______________________________________Date: __________________________

Physician Assistant:_____________________________________Date: __________________________

Medical Director:____Date:____