Dermapen Treatment Consent

Clinic/Salon:_____
Patient's Name (BLOCK LETTERS _____
Address :_____
_____
_____
Email: _____ Mb Tel : _____

Please circle or answer where appropriate:

- ☐ Do you have any current or chronic **medical illnesses** we should know about? (i.e. Thyroid, heart condition, cancer, or cancer in the family, epilepsy, diabetes) Yes No
  Please List: _____
- ☐ Have you had any major or minor **surgery** Yes No
  Please List: _____
  Do you take/use **any medications**, herbal or natural supplements or topicals on a regular or daily basis? (Antibiotics, Hormones, Retin-A, Glycolic Lactic Acid,etc) or Have you taken Accutane or anticoagulants in the last 6 months?
  Details _____ Yes No
- ☐ HAVE YOU GOT/HAD COLD SORES OR HAVE YOU GOT/HAD HERPES? Yes No
- ☐ Do you have or have you been exposed to HIV (AIDS)? Yes No
- ☐ Do you have any permanent make-up, implants or tattoos? Yes No
- ☐ (For women) Are you or could you be **pregnant**? Or Breastfeeding?_____

HYPERSENSITIVITY & FRAGILITY

- ☐ Do you have any **allergies** to medications, foods, latex, Nickel, or other substances? Yes No
  Please List: _____
- ☐ Are you sensitive to skincare products? _____ Yes No

SUN HISTORY & SKIN

- ☐ Any **sun exposure**, used tanning creams or tanning beds in the last 4-6 weeks? Yes No
- ☐ When exposed to sun, do you ☐ Tan only ☐ Tan & Burn ☐ Burn
- ☐ Do you develop skin rashes in reaction to: ☐ Food ☐ Medication ☐ Environment ☐ Light ☐
- ☐ Product Details _____

ABILITY TO HEAL

- ☐ Do you form thick or raised scars (keloid scarring)? Yes No
- ☐ Do you wax or use depilatories? Yes No
- ☐ Does your skin appear fragile? Yes No
- ☐ Do you bruise easily Yes No
- ☐ Do you bleed easily Yes No

SKIN TYPE

- ☐ Does your skin ever flake or feel tight and dry? ☐ Frequently ☐ Occasionally ☐ Rarely
- ☐ Is your skin ever shiny a few hours after cleansing? ☐ Frequently ☐ Occasionally ☐ Rarely
- ☐ How often do you experience blackheads or blemishes? ☐ Frequently ☐ Occasionally ☐ Rarely
- ☐ How noticeable are your pores? ☐ Very ☐ Not Very

PIGMENTATION

- ☐ Is your pigmentation: ☐ Even ☐ Uneven ☐ Birthmark ☐ Pregnancy ☐ Mask

VASCULARITY

- ☐ Broken Capillaries: ☐ Nose ☐ Cheeks ☐ Chin ☐ Forehead ☐ Entire Face
- ☐ Do you blush easily? Yes No

ACNE

- ☐ Do you have any history of acne or periodic breakouts? _____
- ☐ Do you have Rosacea? _____
- ☐ Do you have any areas of concern with acne scarring? _____

To the patient:

It is important that you are informed about your skin condition and proposed treatment including the potential benefits and risks involved. This disclosure is not meant to scare or alarm you; it is simply an effort to better inform you so that you may give or withhold your consent to the treatment program.

I _____ of (address as above) have requested a DermaPen Treatment to attempt to improve my facial expression lines and or skin surface with DermaPen treatment.

The practice of medicine is not an exact science and no guarantees can be or have been made concerning expected results. I understand that several appointments may be necessary to complete the treatment.

Risks and side effects:

Side effects and complications are usually minimal. Occasionally you may experience erythema, bleeding, temporary scarring, dryness and or discomfort. I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and that I have had sufficient opportunity for discussion and to ask questions. I consent to this procedure today and for all subsequent treatments.

I have answered all questions, particularly about my medical history to the best of my knowledge. I have no further questions. I freely consent to the proposed elective treatment, and understand the potential benefits and side effects.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

PLEASE TAKE THE TIME TO READ THIS CAREFULLY AND TO UNDERSTAND ANY ACCOMPANYING INFORMATION.

Photography / Video Release

I, the undersigned, voluntarily consent to the taking, copyright, publication, and use of my picture and/or video footage (my face may be identifiable) and likeness by my Doctor. I only agree to the following uses of these photographs or video footage:

Please check the "YES" box for the categories for which you give consent and the "NO" box for the categories for which you do not give consent.

YES	NO	
☐	☐	**FOR EDUCATIONAL, PUBLICATIONS, INFORMATIONAL PURPOSES, OR RESEARCH.**
☐	☐	**FOR GENERAL ADVERTISING, PUBLICITY, AND PROMOTIONAL PURPOSES.**

Patient's Signature: _____ Date: _____

Patient's Name: _____

Operator's Signature: _____ Date: _____

Operator's Name: _____

PLEASE TAKE THE TIME TO READ THIS CAREFULLY AND TO UNDERSTAND ANY ACCOMPANYING INFORMATION.