

# LAGUNA LASER HAIR, TATTOO REMOVAL & AESTHETICS

## CLIENT INFORMATION FORM

TODAYS DATE \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ SEX (circle one) FEMALE /MALE/TRANS-GENDER

E-MAIL \_\_\_\_\_ (we send out coupons and specials)

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ (home or cell)

HOW WERE YOU REFERRED?

WHO REFERED YOU? \_\_\_\_\_ (\$25 referral credit)

TATTOO SHOP REFERRAL \_\_\_\_\_

COUPON/ADVERTISMENT (circle one) MONEY MAILER, VAL PAK, SANTAN PAPER, INTERNET

WALK IN/ DRIVE BY / OTHER \_\_\_\_\_

WHICH OF OUR SERVICES INTEREST YOU AND WHAT AREAS WOULD YOU LIKE TO HAVE TREATED

\_\_\_\_\_

PLEASE LIST ALL TOPICAL AND ORAL MEDICATIONS AND FACE PRODUCT YOU ARE USING- (Please list all photosensitive ACUTANE, RETIN-A, ANTIBIOTICS, HERBAL SUPPLIMENTS etc.

\_\_\_\_\_

ALLERGIES \_\_\_\_\_

PLEASE LIST IF YOU HAVE ANY PACEMAKERS, MPLANTS, TATTOOS, INJECTABLES, PERMANENT MAKEUP AROUND AREA WANTING TO BE TREATED?

\_\_\_\_\_

ARE YOU PREGNANT? Y / N

FOR YOUR SAFETY PLEASE LIST ANY HEALTH ISSUES SUCH AS DIABETES, HIV/AIDS, ETC.?

\_\_\_\_\_

PREVIOUS LASER OR COSMETIC TREATMENTS OR HAIR REMOVAL HISTORY IF WAXING/THREADING/BLEACHING ETC. (Please specify the date, number of treatments, technology used if known, and skin response/ issues/satisfaction.)

\_\_\_\_\_

**EMERGENCY CONTACT**

**NAME** \_\_\_\_\_ **CONTACT NUMBER** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**EMAIL** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**ELECTRONICAL SIGNATURE AGREEMENT: BY SIGNING YOU AGREE THAT TYPING YOUR NAME ON THE LINE ABOVE IS THE LEGAL EQUIVALENT OF YOUR MANUAL SIGNATURE ON THIS FORM**

**GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

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