M.A.R.C.
MEDICAL AESTHETICS & REJUVENATION CENTER

General Consent Form

Patient Name:_____ Date of Birth:_____
Address:_____
City:_____
State: _____ ZIP: _____
Phone:_____ Email Address:_____
How did you hear about M.A.R.C? Facebook Instagram Yelp Google Referral: _____
Have you had a facial before? Yes_____ No_____ Date: _____
What are your specific skin care concerns? (Circle)

Dry Skin	Age Spots/ Sun Spots	Fine Lines	Oily Skin	Redness
Sensitive Skin	Black Heads	Acne	Hormonal Acne	Uneven Skin Tone

What skin care products are you currently using? BRAND: _____

	AM Skin Care Routine	**PM Skin Care Routine**
Cleanser		
Toner		
Exfoliation or Scrub		
Serum		
Moisturizer		
Sunscreen		
Eye Cream		
Other products or Rx		

Are you pregnant, lactating, or plan on becoming pregnant soon? Yes_____ No____
List all known allergies (food, products, ingredients, etc.)

_____

Have you ever had a reaction to skin care products or ingredients? Yes_____ No_____
Explain:_____
Are you using prescribed exfoliants? (Retin-A, Epiduo, Differen, Renova, Accutane, etc.) Yes____ No_____
Explain:

_____

Are you currently taking any medication that could interfere with a facial treatment? Yes____ No___
Explain:

_____

Please Circle if it applies to you:

Sunburn or windburn recently	Pregnant or nursing	Metal Pins or plates	Pathological skin condition	Heart beat regulating medication / heart complaints
Pacemakers or other battery operated and electrical implant	Neurological disorders including epilepsy or multiple sclerosis	Skin conditions in an active state accompanied by inflammation, weeping or soreness	Allergy to Aspirin &/or Salicylic sensitivity	Allergic to Citrus fruits (Orange, Grapefruit, lemons)
History of being “highly allergic”	Currently using antibiotics	Use of Accutane within the last 12 months	Laser resurfacing within the last 12 weeks	Using Glycolic Acid products
Use of Retin-A®, Renova®, retinoids (Vitamin A) in the last 4-weeks	Recent peels within 8 weeks	Herpes Virus (cold sores on mouth)	Laser hair removal on area to be treated within the last 6 weeks	Chemotherapy or Radiation
Allergic to Chocolate, Cocoa, Raspberry	Allergic to Pineapple, Papaya or Mango	Seizures or epilepsy	Migraines	HIV/AIDS
OTHER:				

I understand that redness, sensitivity, peeling or other reactions may occur from a facial treatment. If I experience any discomfort during the session, I will immediately inform the aesthetician so that the products and/or technique may be adjusted to my level of comfort. I further understand that aestheticians are not qualified to diagnose, prescribe or treat any disease or illness and that a facial should not be a replacement for medical treatment. The treatments I receive here are voluntary and I release Medical Aesthetics and Rejuvenation Center, LLC and/or the skin care professional from liability and assume full responsibility thereof.

Patient Name: _____

Patient Signature:_____ Date:_____