réjuvapen
FRACTIONAL COLLAGEN INDUCTION THERAPY

CONFIDENTIAL MEDICAL FORM

ACHIEVE Beautiful SKIN MEDI-SPA VIERA

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Phone: _____ Cell Phone: _____

Referred By: _____ Email: _____

To avoid unforeseen complications, please answer the following questions:

- ☐ YES ☐ NO Are you under the age of 18? Legal guardian initials: _____
- ☐ YES ☐ NO Have you had any aspirin or blood thinning products within the last 7 days?
- ☐ YES ☐ NO Have you had any mood altering drugs within the last 8 hours?
- ☐ YES ☐ NO Do you have any history of cold sores, herpes, or fever blisters?
- ☐ YES ☐ NO Are you sensitive to latex?
- ☐ YES ☐ NO Have you had a chemical or laser peal? Is so, when? _____
- ☐ YES ☐ NO Do you have problems with healing?
- ☐ YES ☐ NO Are you currently undergoing radiation or chemotherapy?
- ☐ YES ☐ NO Are you currently using Retin-A or Alpha Hydroxy skin care products?
- ☐ YES ☐ NO Are you allergic to any metals?
- ☐ YES ☐ NO Are you taking any anti-inflammatory medication or steroids?
- ☐ YES ☐ NO Are you suffering from withdrawal from caffeine products?
- ☐ YES ☐ NO Are you allergic to topical desensitizers (I.E. "Caine" family of drugs)
- ☐ YES ☐ NO Do you have a history of skin diseases or remarkable skin sensitivities?
- ☐ YES ☐ NO Are you currently taking vitamin A and/or E in any form?
- ☐ YES ☐ NO Are you pregnant or nursing?
- ☐ YES ☐ NO Are you currently being treated by a dermatologist?

Please check any of the following that pertain to you.

- ☐ Heart Conditions
- ☐ Allergies to Makeup
- ☐ Accutane Treatment
- ☐ Chronic Skin Disease
- ☐ Shortness of Breath
- ☐ Keloid or Hypertrophy Scars
- ☐ Keloid Formation
- ☐ Smoke
- ☐ Hemophilia
- ☐ Diabetes
- ☐ Hepatitis/Jaundice HIV
- ☐ Kidney Disease
- ☐ Tendency to develop fever
- ☐ Blisters on lips
- ☐ Hyper-pigmentation (darkening of skin)
- ☐ Excessive Bleeding from minor injuries
- ☐ Chest Pains
- ☐ Glaucoma
- ☐ Epilepsy/Seizures
- ☐ Stroke

Medications taken:

Doctor's Name: _____

Phone: _____

Signature: _____

Date: _____

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PATIENT CONSENT FORM

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RUJAVPEN SHOULD NOT BE USED BY PATIENTS UNTIL THERE HAS BEEN A COMPLETE DISCUSSION OF THE RISKS AND WRITTEN INFORMED CONSENT HAS BEEN OBTAINED.

PATIENT CONSENT

My _____ treatment with the REJUVAPEN has been personally described to me by _____.

The following points of information, among others, have been specifically discussed and made clear and I have had the opportunity to ask any questions concerning this information:

____ I, _____ (patients name), understand that REJUVAPEN will be used to treat skin tightening, acne scars, wrinkles or lift and firm of the skin. I have been examined by my physician and have been cleared for this procedure.

____ Any and all follow-up treatment (if necessary) needs to be scheduled with a licensed medical provider to determine if additional treatments are necessary.

____ I understand that most patients look as though they have a moderate to severe sunburn and my skin may feel warm and tighter than usual. Most patients usually recover within 24 hours or less. Because the device may penetrate the skin there can be risk of infection, if this occurs, a follow up appointment with be required for further treatment.

____ REJUVAPEN may not be used directly on any of the below conditions. I have disclosed any of the health concerns below that apply to me:

- Open sores or lesions
- Skin Cancer
- Broken or irritated skin, including conditions such as hives or dermatitis
- Any type of skin infections
- Any stage of melanoma
- Rosacea
- Raised surface
- Active acne
- Eczema

I now authorize _____ to begin my treatment with REJUVAPEN.

Patient/Caretaker _____

Address _____ Telephone _____

Patient Signature _____ Date _____