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LASER & SKIN CARE

Confidential Patient Case History – Beyond Whitening

Name _____ Date _____ DOB _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work _____ Mobile _____ Other _____

How did you hear of us? Dallas Voice Internet Observer Radio Passport Other _____

Email: _____

General Medical History

Accutane	YES	NO	Heart Condition	YES	NO
Acne	YES	NO	Hemophilia	YES	NO
Allergies (drug or latex)	YES	NO	Hepatitis	YES	NO
Canker Sores	YES	NO	High Blood Pressure	YES	NO
Carcinoma (cancer)	YES	NO	HIV Positive	YES	NO
Cold Sores	YES	NO	Keloid Scars	YES	NO
Contact Lenses	YES	NO	Metal pins in body	YES	NO
Dermatitis/Eczema	YES	NO	Pacemaker	YES	NO
Diabetes	YES	NO	Retin A	YES	NO
Epilepsy	YES	NO	STD'S	YES	NO
Genital Herpes	YES	NO	Tuberculosis	YES	NO
Implants of any kind	YES	NO			

Medical Problems we should know of? _____

Are you currently pregnant or trying to get pregnant ? _____

Taking any types of drugs including any mood altering drugs? Tetracycline Sulfa drugs Accutane

(others please list) _____

Have you tried whitening your teeth in the past?_____

If yes, what product did you use?_____

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Patient Consent for Beyond White Tooth Whitening

Patient Name: _____

Procedure: Tooth Whitening
Device: Beyond White lamp with hydrogen peroxide gel

I hereby authorize and direct any associates or assistants of Advanced Skin Fitness to perform Beyond White Tooth Whitening on me. **Multiple treatments** may be required to achieve cosmetically acceptable results. In rare cases, patients may not experience any improvement in the coloration of their teeth even with multiple treatments. I specifically acknowledge that no guarantees or warranties have been made concerning the results of the procedure.

I understand that whitening treatments are considered generally safe by most dental professionals and are sold over-the-counter to individuals. I understand that although my cosmetologist has been trained in the proper use of the Beyond White System, the treatment is not without risk.

I understand that some of the potential complications of this treatment include, but are not limited to the following: (please initial each statement)

_____ During the first 24 hours after the Beyond White treatment, some clients can experience some tooth sensitivity. While uncommon with the Beyond White system, tooth sensitivity is a common side effect of peroxide-based tooth whitening. It is usually mild, but it can be worse in some individuals. Normally, tooth sensitivity following the use of peroxide-based whitening products subsides within 24 hours. People with existing sensitivity, recently cracked teeth, abfractions (micro-cracks), open cavities, leaking fillings or other dental conditions that cause sensitivity may find that those conditions increase or prolong tooth sensitivity after the Beyond White treatment.

_____ The Beyond White treatment involves three, 20-minute sessions during which the mouth is kept open for the entire treatment by a plastic retractor. This could result in dryness or chapping of the lips or cheek margins, which can be treated by application of lip balm, petroleum jelly or Vitamin E cream.

_____ After the Beyond White treatment, it is natural for the teeth to regress somewhat in their shading over time. This is natural and should be very gradual, but it can be accelerated by exposing the teeth to various staining agents. I understand that the results of the treatment are not intended to be permanent and therefore, repeat or touch-up treatments may be needed for me to maintain the tooth shade I desire for my teeth.

_____ I understand that for 24 hours after the Beyond White treatment eating or drinking dark staining substances such as: coffee, tea, red wine, soy sauce or cola, smoking cigarettes or using colored toothpaste will lessen the effectiveness of my treatment and has a possibility of permanently staining my teeth.

ACKNOWLEDGEMENT

I understand that I release Advanced Skin Fitness and its associates, the Medical Director, the technician performing services, and any other person involved in my treatment from any liability associated with complications from the Beyond White procedure. I am aware that Advanced Skin Fitness has a 24 hour cancellation policy. Similarly, I will be charged $100 for any broken appointment without 24 hour cancellation. I understand that all procedures are priced per treatment. I understand that no guarantees can be made and all payments are non-refundable. By my signature below, I certify that I have read and fully understand the contents of this permission and authorize the performance Beyond White Tooth Whitening by the staff of Advanced Skin Fitness.

Patient or legal guardian signature and date _____

Witness signature and date _____

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Pre-treatment shades:

Upper teeth:_____

Lower teeth:_____

Post treatment shades:

Upper teeth:_____

Lower teeth:_____

Client signature:_____Date:_____

Witness:_____Date:_____

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Credit Card Charge Authorization Agreement

We request the courtesy of a 24 hour notice in the event an appointment needs to be cancelled or rescheduled. A $75 no show fee for facial treatments and a $100 no show fee for laser treatments will apply in the event advanced cancellation notice is not given. Appointments booked same day of service will be assessed a no show fee should cancellation become necessary. For treatments that are pre-paid, the pre-paid treatment will be forfeited without 24 hour notice of cancellation. Thank you for your cooperation.

I, _____,

hereby authorize Advanced Skin Fitness to charge my credit card used for my treatments in the amount of $75 for a missed facial treatment or $100 for a missed laser treatment.

I have read this entire agreement and understand that I will be held fully responsible for its terms and charges. I agree not to chargeback Advanced Skin Fitness, as long as I receive the services that are entitled to me and guidelines are followed for my rescheduling and cancellation of appointments. Twenty-four hour notice is required for all rescheduling and cancellations.

Name On Card: _____

Signature: _____

Credit Card Billing Address: _____

City, State, Zip: _____

Telephone: (_____) _____

Date: ____/____/____