DivineInterventions

Patient/Customer Information

Our **first** concern at Divine Interventions is patient safety. Please fill out this form to ensure that any medical conditions, medications, nutritional supplements or anything you feel important to disclose is reported BEFORE treatment. Some treatments, medications and conditions may cause adverse reactions, resulting in complications or unintentional injury. If you have been tanning or have recently traveled to a sunny destination, it is extremely important for you to let us know. Thank you.

Personal Information:

Name: _____ Today's Date: _____

Address 1: _____ Cell#: _____

Address 2: _____ Home#: _____

Date of birth: (MM/DD/YYYY) _____ Email: _____

AB Health Care #: _____

Occupation: _____

How or /where did you find out about us? (Please check):

☐ Google ☐ Facebook ☐ Instagram ☐ Elevator Ad

☐ Other (please list): _____ ☐ Referred by (please list): _____

Please indicate what you have come to talk to us about, or anything that concerns you? (Please check):

☐ Stretch Marks	☐ Wrinkles	☐ Headaches
☐ Hallow Under eyes	☐ Dryness	☐ Skin Tags
☐ Brown Spots	☐ Droopy Eyelids	☐ Freckles
☐ Cystic Acne	☐ Oily Skin	☐ Melasma
☐ Broken Capillaries	☐ Thin Lips	☐ Scars
☐ Enlarged Pores	☐ Uneven Skin	☐ Rosacea
☐ Milia	☐ Bridged Nose	☐ Acne
☐ Unwanted Hair	☐ Excess Sweating	☐ Body Treatments
☐ Uneven Jawline	☐ Frown Lines	☐ Skin laxity
☐ Urinary Incontinence	☐ Moles	☐ Other (Please describe)

_____

Emergency Contact

Name:_____

Phone Number: _____

Relationship to you:_____

Medical History:

Are you currently on any medication(s)? YES ☐ NO ☐

If YES, please list: _____

Do you have any allergies? YES ☐ NO ☐

If YES, please list: _____

Are you currently under the care of a physician? YES ☐ NO ☐

If YES, please list what for: _____

Do you suffer from any of the following conditions? (Check all that apply):

☐ Epilepsy	☐ TMJ	☐ Photosensitivity	☐ Auto-Immune Disease
☐ Arthritis	☐ Cancer	☐ Blood Disorders/Clotting	☐ Hyper-Hydrosis
☐ Polycystic Ovaries (PCOS)	☐ Keloid Scars	☐ Diabetes	☐ Herpes
☐ Hormonal Imbalances	☐ Cold Sores	☐ Hyper/Hypo Pigmentation	☐ HIV/AIDS
☐ Cardiac Diseases	☐ Psoriasis	☐ Acne	☐ Hepatitis
☐ Multiple Sclerosis	☐ Lumps/Cysts	☐ Migraines	☐ Other: _____

Do you have any metal implants? YES ☐ NO ☐

If YES, please list: _____

Do you smoke? YES ☐ NO ☐

For Female Clients Only:

Are you pregnant or trying to get pregnant? YES ☐ NO ☐

Are you breastfeeding? YES ☐ NO ☐

Skin Care History:

Are you currently under the care of a dermatologist? YES ☐ NO ☐

If YES, please list what for: _____

Are you currently using topical creams or skin care products?

YES ☐ NO ☐

If YES, please list: _____

Do you have a tan, or have you been to a sunny location within the last 4 weeks?

YES ☐ NO ☐

How often do you wear sunscreen?

FREQUENTLY ☐ OCCASIONALLY ☐ RARELY ☐ NEVER ☐

How often do you use tanning beds?

FREQUENTLY ☐ OCCASIONALLY ☐ RARELY ☐ NEVER ☐

How often do you burn from sun exposure?

FREQUENTLY ☐ OCCASIONALLY ☐ RARELY ☐ NEVER ☐

Which of the following best describes your skin?

Very oily, large pores ☐ Oily ☐ Dry ☐ Combination ☐ (oily in some spots and dry in some spots) Sensitive ☐ (reactive to certain products)

Photo Record

For adequate record keeping I consent to have this clinic's staff take before, during and after treatment close-ups photographs of the involved area(s). These photos will be used for medical records and shall be treated with the same confidentiality as the remainder of my records.

_____

Initial

Disclosure and Informed Consent

Is there anything that you feel that we should know that may affect your treatments? Please list anything you feel would help us in our ability to deliver safe and effective treatments to you:

_____

It is your duty to inform us of any changes in skin condition(s), sun exposure, medical diagnoses, medications, and any supplements you take. It is also your responsibility to inform us of any adverse reactions, abnormalities or unexpected as a direct or suspected result from your treatment(s) received from Divine Interventions. We are here to help.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS AND PURPOSE OF THIS INFORMATION PROVIDED IN THIS DOCUMENT. I GIVE MY CONSENT TO THE STAFF OF DIVINE INTERVENTIONS TO USE THIS INFORMATION TO PERFORM MY TREATMENTS AT DIVINE INTERVENTIONS. I UNDERSTAND THAT ANY CHANGES TO THIS INFORMATION WILL BE MY SOLE RESPONSIBILITY TO REPORT TO DIVINE INTERVENTIONS. IF I FAIL TO REPORT OR RELEASE INFORMATION REGARDING MY HEALTH, SUN EXPOSURE AND ANY OTHER CHANGES IN MY INFORMATION, AS WELL AS A TREATMENT RESULTING IN AN ADVERSE OR ANY UNFORESEEN INJURY, I RELEASE ANY LIABILITY FROM THE SERVICE PROVIDER AND FROM DIVINE INTERVENTIONS.

Patient Name	Signature	Date

Staff Name	Signature	Date

Divine Interventions' Policies

Appointments:

- Cancelations require **24** hours notice.
- Please contact us via telephone at (780) 439-1208 or email info@divineinterventions.ca
- Cancelations less then 24 hours and/or No-Shows will result in a fee of **$50.00** being charged to your credit card on file.
- If you are later than 10 minutes for your appointment you will be required to rebook unless the technician can still provide the service without causing them to run late.
- Reoccurring (more than 3 times) cancelations with less than 24 hours notice and/or no-shows, you will be required to deposit (50%) of the entire session cost.
- If you have prepaid for package deal and cancel with less than 24 hours or no-show to your scheduled appointment(s), we have the right to deduct the cancellation fee from the package balance and you must pay the balance to continue treatment.

Harassment:

- Divine Interventions does not tolerate any form of harassment or disrespect towards staff or management.
- Divine Interventions is committed to providing a clinic in which the dignity of every individual is respected.

*We reserve the right to refuse appointments to any client who has demonstrated disregard of our policies.

Credit Card Authorization

I,_____, authorize Divine Interventions to charge my credit card for the agreed upon fees. I understand that my information will be saved to file for future transactions on my account.

Credit Card Information

Card Type: ☐ MasterCard ☒ VISA

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____ CVV: _____

Cardholder Postal Code (from credit card billing address): _____

CLIENT CONSENT:

By signing below, I confirm that I understand the policies of Divine Interventions and agree to the terms.

Patient Name	Signature	Date

Staff Name	Signature	Date