

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: _____ Email: _____
(MM/DD/YYYY) _____
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):

- | | | |
|---|--|--|
| <input type="checkbox"/> Stretch Marks | <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hallow Under eyes | <input type="checkbox"/> Dryness | <input type="checkbox"/> Skin Tags |
| <input type="checkbox"/> Brown Spots | <input type="checkbox"/> Droopy Eyelids | <input type="checkbox"/> Freckles |
| <input type="checkbox"/> Cystic Acne | <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Melasma |
| <input type="checkbox"/> Broken Capillaries | <input type="checkbox"/> Thin Lips | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Enlarged Pores | <input type="checkbox"/> Uneven Skin | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Milia | <input type="checkbox"/> Bridged Nose | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Unwanted Hair | <input type="checkbox"/> Excess Sweating | <input type="checkbox"/> Body Treatments |
| <input type="checkbox"/> Uneven Jawline | <input type="checkbox"/> Frown Lines | <input type="checkbox"/> Skin laxity |
| <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Moles | <input type="checkbox"/> 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):

- | | | | |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> TMJ | <input type="checkbox"/> Photosensitivity | <input type="checkbox"/> Auto-Immune Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood Disorders/Clotting | <input type="checkbox"/> Hyper-Hydrosis |
| <input type="checkbox"/> Polycystic Ovaries (PCOS) | <input type="checkbox"/> Keloid Scars | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Hormonal Imbalances | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Hyper/Hypo Pigmentation | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Cardiac Diseases | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Acne | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Lumps/Cysts | <input type="checkbox"/> Migraines | <input type="checkbox"/> 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 Sensitive
(oily in some spots and dry in some spots) (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

- Cancellations require **24** hours notice.
- Please contact us via telephone at (780) 439-1208 or email info@divineinterventions.ca
- Cancellations less than 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) cancellations 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.

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