Waxing Intake Form

Date:

Client Information

Name: _____ Birthday: _____/_____/_____

Cell: _____ Anniversary: _____/_____/_____

Email: _____

Skin Condition

How would you describe your skin? (Please Circle)

Normal Dry Oily Sensitive

What skin care products do you use and how frequently?

_____

_____

____**What allergies do you have?** Please list all.

_____

_____

____

Client Health

Please list all medications taken in the last 6 months and any treated medical issues in the last year or those that are ongoing. Please be as detailed as possible. This is very important as many medications or conditions can affect your skin during a service.

_____

_____

_____

Please circle any of the following medications, products or treatments you have had in the last year.

Antibiotics, Accutane, Adapalene, Alustra, Avage, Differin, Isotretinoin, Renova, Rentin-A, Tazarac, Tazarotene, Tretinoin, Laser Resurfacing, Corticosteroids, Hydroquinone, Trilumena, Benzoyl Peroxide, AHA or BHA Exfoliating Acids, Topical Antibiotics, Retinol, Salicylic Acid, Microdermabrasion, Facials, Dermaplanning, Chemical Peels, Dermabrasion

Cancellation, No-Show, and Tardy Policy

We look forward to serving you and want every guest to have the best experience possible. To book any appointment we do require a card on file to hold your appointment time. That being said, **we require a 24-hour notice for cancelations of any service provided at Hair Peace. No-Call, No-Shows will be charged 50% of the services booked as a fee to the card on file**. Guests who arrive late for services may need to reschedule their appointments so that they do not interfere with other appointments booked. We do ask that you call beforehand if there are any issues making your appointment so we can accommodate you appropriately. By signing below at the bottom of this page, you are acknowledging these policies and agree to follow them.

Waxing Release

By signing this form below, I _____ understand that waxing or tinting may cause skin injury such as, but not limited to skin irritation, lifting, bruising, redness, allergic reactions, or swelling. I have read the information and listened to the information and agree to always provide service provider with all information that may affect my service such as, but not limited to past treatments, skin care products, health or medical conditions, etc. as accurate to my knowledge. I give my permission to service provider to perform the scheduled services that we have discussed and we hold Hair Peace or any of its employees or partners harmless of any liability that may result of treatments received. I agree to follow all post care instructions set by my service provider. I also understand that my esthetician will take every precaution to minimize or eliminate any negative side effects as much as possible.

Minor Release:

I, _____, the parent/guardian of, _____, hereby allow said minor to receive the scheduled services. I have read the all the above information and give (minor name)_____, age: _____ permission to receive the following services from the service providers of Hair Peace:_____

_____

Printed Name: _____ Signature:

_____