A&WMC
PEELING TREATMENT

Name:_____Date:_____
(First) (Last)

Date of Birth:_____Age:_____Weight:_____ Heigth:_____

Home Address:_____

City:_____State:_____Zip:_____

Cell Phone:_____ Occupation:_____

Email Address:_____

Have you had Botox or fillers? Yes ( ) No ( ) When:_____

Prior peeling treatments Yes ( ) No ( ) When: _____

Prior treatment with Radiofrequency, Laser, CO2 Yes ( ) No ( ) When: _____

Do you use Retinol? Yes ( ) No ( ) _____

Do you use sunblock? Yes ( ) No ( )_____

Last prolonged exposure to sun or tanning bed: _____

Medical History

History of Herpes: Yes ( ) No ( ) Last episode: _____

Any skin disorders -Psoriasis, eczema, rosacea- : Yes ( ) No ( ):_____

Detail medical conditions:_____

Surgical procedures:_____

List of medications and vitamins:_____

Allergies:_____

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CONSENT FOR PEELING TREATMENT

I give my informed and voluntary consent and I authorize Dr. Angelica Hernandez and the staff of Adolescent & Women Medical Care to administer treatment for skin hyperpigmentation.
I understand that a chemical peel is a controlled exfoliation treatment using a chemical solution applied to the skin to improve skin texture, tone and overall appearance.

I certify that I have been fully informed of the nature, purpose, expected benefits and possible complications of this procedure. I understand that no specific outcomes can be guaranteed, as outcomes may vary depending on individual response.
I confirm that I have disclosed all current and past medical conditions, illnesses and medications to the medical staff.

I agree to have before and after photographs taken, and consent to the application of topical anesthetics as part of this procedure.

I fully agree to release and hold harmless Adolescent & Women Medical Care, Dr. Angelica Hernandez and all affiliated parties, from any liability that may arise as a result of this treatment now and in the future.
I certify that I have been given the opportunity to ask questions and that I have read and fully understand the content of this consent form.

Patient Name:_____

Signature:_____

Date:_____