SASAKI INNOVESSENCE SKINCARE
800 S. FAIRMOUNT AVE., SUITE 319
PASADENA, CA. 91105
(626) 796-0530
WWW.DRSASAKI.COM

PLEASE PRINT

Date: ____________

Patient's Name: ____ Age: _________ Date of Birth: _____________
Home Address: _______________________________ City: _______________ State: ______ Zip Code: ________
Home Phone: ( ) __________________ Married: ___ Single ___ Widowed: ___ Divorced: ___ Separated: ___
Cell Phone ( ) _______________________ Email: ____
Patient's Occupation: _____________________________________ Employer: ____________________________
Business Address: ____ Business Phone: ( ) _______________

Patient Referred By: ______________________________________ Phone Number: ( ) _________________
May we send a thank you to the person who referred you? Yes ______ No ______

For emergency notification please list a relative not living at the same address as the patient.
Nearest relative name: ________________________________ Phone Number: ( ) _____________________

If patient is a minor, please complete the following on the financial responsible party:
Name: __________________________ Relationship: ______________ Phone Number: ( ) ______________
Address: ________________________________ City: _________________ State: ________ Zip Code: _______
Occupation: ________________________________ Employer: ____
Business Address: ____ Business Phone: ( ) _________________

Are you allergic to any medications? Yes _____ No _____
Please List: ____
____

POLICIES:

Please note that we do have a 24 hour cancellation policy, failure to give notice will result in a $25 fee.

We will gladly exchange or replace any defective product within 14 days of purchase.
Make-up and Skincare device sales are final.

Payment is due at the time of service.

Please be advised Sasaki InnoVessence SkinCare does NOT participate in any HMO, PPO, POS Plans or Medicare.

SASAKI INNOVESSENCE SKINCARE

1. Are you currently or within the last year under a physician's care? If yes, who?
   ____
2. Please define any health problems past or present. Diabetes, Thyroid, Heart Problems, Cancer, Hormone Imbalance, Hysterectomy, Epilepsy, HIV, Hepatitis.
   ____
3. Please list all medications or vitamins that you take regularly and reasons for usage.
   ____
   ____
4. Do you use Retin-A? Yes _____ No _____
5. Have you ever used Accutane (Acne Drug)? Yes _____ No _____
6. Are you currently on a restricted diet? Yes _____ No _____
7. Have you undergone any surgery in the last 9 months? If so, what details can you provide?
   ____
8. Do you smoke? Yes _____ No _____ How much? ______________________________________
9. What is your ethnic origin? ____
10. Are you taking oral contraception? Yes _____ No _____ What Brand? ________________________
11. Are you or are you trying to become pregnant? Yes _____ No _____
12. Are you due for your menstrual period within this next week? Yes _____ No _____
13. Do you have regular exercise and sleep patterns? Yes _____ No _____
14. What concerns do you have about your skin? _____________________________________
15. Do you tan? Yes _____ No _____
16. Do you tan evenly? _____ Blotchy? _____
17. Have you had a chemical peel? Yes ___ No _____
18. What products are you currently using? ____
19. Are you troubled by a breakthrough oily shine during the day? Yes _____ No _____
20. Do you ever experience a skin breakout? Yes _____ No _____
21. How much plain water do you consume daily? _____ Glasses
22. Do you take any laxatives or diuretics? Yes _____ No _____
23. Do you ever experience any flaking or tightness of your skin? Yes _____ No ______
24. If you sunbathe, do you use a protection on your skin? Yes _____ No ______
25. Do you burn easily in moderate sunlight? Yes _____ No _____
26. Do you blush easily when nervous? Yes _____ No ______
27. Do you have a tendency to redness? Yes _____ No ______
28. Have you ever suffered any sinus problems? Yes _____ No _____
29. Do you drink more than 5 cups of regular tea or coffee daily? Yes ______ No _____
30. Do you take any stimulants or slimming tablets? Yes _____ No _____
31. Do you consider your pain threshold low, medium, or high? ________________
32. Do you prefer a massage to be firm or light pressure? ________________________________
33. Have you ever had a reaction to a stimulus such as: (please check)

    _____ Cosmetic   _____ Foods   _____ Pollen
    _____ Metals   _____ Animals   _____ Other ________________________

    List any drug allergies: ____

I give my consent for evaluation and treatment.
Signed: ____ Dated: ______________________

If patient is a minor – I give my consent for evaluation and treatment as the Parent/Guardian
Signed: ____ Dated: ______________________

SASAKI INNOVESSENCE SKINCARE

TO ALL PATIENTS

PLEASE BE ADVISED THAT YOU ARE USING A PHYSICIAN GRADE TREATMENT PRODUCT WHEN YOU PURCHASE ANY OF OUR SKIN CARE. THESE PRODUCTS ARE NEVER INTENDED FOR YOU TO SHARE WITH ANYONE.

BY SIGNING BELOW, YOU ARE ACKNOWLEDGING THAT YOU HAVE BEEN ADVISED NOT TO SHARE YOUR TREATMENT PRODUCTS WITH ANYONE DUE TO THE POTENTIAL RISK YOUR FRIEND/RELATIVE MIGHT EXPERIENCE.

BY SIGNING BELOW, YOU ARE ALSO ACKNOWLEDGING THAT YOU WILL USE PRODUCTS ONLY AS DIRECTED BY PRODUCT COMPANY OR BY DR. SASAKI AND/OR DR. HAKIMI

SIGNATURE: ________________________________ DATE: ____________

PRINTED NAME: __________________________

PHONE NUMBER: _________________________

SKIN CARE TREATMENT CONSENT

- Prior to receiving any treatment, I am stating that I have disclosed any condition that may be relevant to my treatment such as: pregnancy, allergies, herpes history, use of Retin-A, Accutane, etc. (not an all inclusive list). I know I must stop all treatment products 3 days before and for 3 days after a treatment.
- I understand there may be some degree of discomfort, maybe stinging, pin-pricking, hotness or tightness.
- I understand there are no guarantees as to the results of this treatment due to variables such as smoking, sun damage, climate, etc.
- I may or may not peel. To achieve maximum results multiple treatments may be necessary.
- This treatment uses medically based products but no medical claim is expressed or implied.
- Although complications are very rare, sometimes they do occur. I agree to contact the doctor/technician immediately for prompt treatment.
- I agree to refrain from using a tanning bed for 14 days after a treatment. Spray tan is OK.
- I agree to refrain from direct sun exposure while I am undergoing treatment, and the use of sunblock with an SPF 15-45, or a total block product with ZincOxide is mandatory following treatment.
- I will avoid cardio workouts post treatment for 24 Hours.
- I state that I have not had any type of chemical peel within the last 14 days.
- I understand that it is not recommended to have another chemical peel within 14 days after this treatment.
- NO facial waxing for 10 days post treatment.
- I have read the above terms/conditions and I agree to follow all of the above instructions and any additional instructions given during the course of my treatments.

Signed: ______________________________________ Date: ___________________