Maya Med Spa

SilkPeel® Dermalinfusion® System

6330 Broadway Blvd. Suite B, Garland, TX 75043
469-209-6999

Patient Informed Consent Form

The SilkPeel system is a safe and highly effective treatment for simultaneous exfoliation of the skin with delivery of a topical formula to target a specific dermatological condition. Exfoliation promotes the reduction of fine lines, wrinkles, minor scars, acne, stretch marks, and sun damage. It also regenerates the epidermal cell structure resulting in skin elasticity and more youthful, pliable, smooth skin. Topical formulas penetrate the skin to treat specific conditions such as acne, hyperpigmentation, photo damage, environmental stress, dehydration and fine line wrinkles. The SilkPeel treatment performed with your practitioner's recommended pre- and post-treatment skin care regimen promotes optimal outcomes.

(Initial)

____ I acknowledge that I might experience a scratchy, stinging sensation during the treatment. This sensation will subside during the post-treatment protocol.

____ I acknowledge that if I suffer from acne, the condition may temporarily look worse after the treatment, but will improve after additional treatments.

____ I understand that if I fail to use sunscreen, I am more susceptible to sunburn and hyperpigmentation. Exercise should be limited after the treatment for 24 hours.

____ I acknowledge that I have not been on Accutane for acne therapy during the past six months. I acknowledge that I have not been using Retin-A for the past two weeks. I will discontinue the use of Retin-A for 1-3 days after therapy.

____ I acknowledge that facial telangiectasia (small blood vessels) is sometimes more apparent immediately after the treatment when the skin is thin and will diminish after re-epithelialization (buildup of dead cells).

____ I agree to remove my contact lenses prior to the procedure (if applicable).

____ I acknowledge that if I am prone to cold sores (herpes) around the mouth or facial area, I may need a prescription for Zovirax from mu medical doctor prior to having the treatment and avoid all treatments during breakouts.

____ I understand that my physician and/or the operator use tools that are either disinfected or disposable.

____ I acknowledge that my skin might experience temporary tightness, redness, or slight swelling which appears in a few hours or less, depending on my skin's sensitivity.

____ The following physical or dermatological condition(s) apply to me:
□ pregnant or lactating □ rosacea □ salicylate or aspirin sensitivity □ none

I hereby agree to have the SilkPeel treatment performed on my skin and follow all post-treatment protocols.

_____ _____

Signature Date

Patient Information

Patient Name: _____ Age: _____ Sex: M F DOB: ___/___/_____
Last First Initial

Address: _____
Street City State Zip Code

Home Phone: ( ) _____-_____ Business Phone: ( ) _____-_____

SSN: _____ E-Mail: _____

Spouse: _____ DOB: ____/_____/_____ SSN: _____
Last First Initial

IF PATIENT IS A MINOR OR FULL-TIME STUDENT PLEASE FILL IN BELOW

Parent/Guardian Name: _____ Sex: M F DOB: ___/___/_____
Last First Initial

Address: _____
Street City State Zip Code

EMERGENCY CONTACT:

Name: _____ Sex: M F DOB: ___/___/_____
Last First Initial

Phone Number: ( ) _____-_____ Relationship to Patient: _____

Were you referred to us? Yes or No

If yes, by who? _____

Patient History

Are you pregnant, nursing, or planning a pregnancy soon? Yes No

Do you have any concerns with the following? (Please circle)

Fine lines	Wrinkles	Thin Lips	Thin Lips	Facial Fullness
Neck Wrinkles	Brown Age	Large Pores	Blotchy Skin	Acne Scars
Length of Eyelashes	Darkness of Eyelashes	Fullness of Eyelashes	Sun Spots	Skin Rejuvenation
Unwanted Hair	Abdominal Area			

Have you ever had any laser treatments? Yes No
If yes, when?

_____

_____

__

Maya Med Spa

SilkPeel® Dermalinfusion® System

6330 Broadway Blvd. Suite B, Garland, TX 75043

469-209-6999

Do you have any history of the following? (Please circle)

Heart Disease	Diabetes	Skin Cancer/Suspicious Moles	Skin Injury
Bleeding Disorders	Excessive Bruising	Abnormal Scarring	Cold Sores/Fever Blisters

Do you have any skin related allergies? Yes No
If yes, please specify _____
_____

Do you have any allergies to medication? Yes No
If yes, please specify_____
_____

Are you taking any of the following? (Please circle)

Aspirin/ Ibuprofen	Anti-coagulants (blood thinners)
Thyroid medication	Appetite depressant/ Diet Pills
Sedatives	Tranquilizers
Hormones/ Contraceptives	Insulin
Cortisone	Accutane within the last 6
Hydroquinone (Bleaching)	Retin A
Vitamin/ Herbal supplements	Oral/ Topical Medication

PLEASE LIST **ALL** CURRENT MEDICATIONS:

_____
_____
_____
_____
____