

Alizetis Consultation Form



PLEASE TELL US ABOUT YOURSELF

Name: _____ Age: _____

Address: _____

Email Address: _____

Phone Number: _____

I _____, give consent to the service provider at Alizeti's Studio to perform the following wax services.

How often do you have waxing done? _____

Have you ever had a bad reaction to a waxing service? **YES** [] **NO** []

If yes, please describe:

Do you have any tendencies to:

[] **Bumps** [] **Bruising** [] **Hyper-pigmentation** [] **Ingrown Hair** [] **Scarring**

DO YOU CURRENTLY HAVE/HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Do you have any medical condition that could compromise your skin and / services being offered? **YES** [] **NO** []

Name of Doctor _____

Are you allergic to anything? **YES** [] **NO** [] Are you diabetic? **YES** [] **NO** []

Do you have any STD/STI? **YES** [] **NO** [] Cancer? **YES** [] **NO** []

Eczema/Psoriasis? **YES** [] **NO** []

Have you taken Accutane within the past 6-12 months? **YES** [] **NO** []

Are you using, Retin-a, Differin or Renova? **YES** [] **NO** []

My signature acknowledges that I have read and agreed to receive the treatments or series of treatments listed above and that I will adhere to all the aforementioned statements I have initialled.

Signature: _____ Date: _____

I am under the age of 18 and my guardian/parent _____ approves of me having the service by Alizeti's Studio.

WE HAVE THE RIGHT TO REFUSE SERVICES FOR ALL WAXING IF PROPER HYGIENE IS NOT FOLLOWED. FOR BRAZILIAN AND BIKINI WAXES, PLEASE USE THE PROVIDED WIPE TO CLEANSE AREA.

M 246-232-2333
alizetistudio@gmail.com or
zoelic@live.com

