

ALLERGIES: Drugs _____

Other _____

Medication	Dose	Times per Day

I hereby declare that all information provided on this form is complete and true to the best of my knowledge.

SIGNATURE

DATE

Consent Form

I voluntarily consent to allow Dr. Norman Schultz or his nurse, to perform the services I have chosen. I understand any and all risks that the doctor or his nurse has explained to me. I agree that I have disclosed all health information to my knowledge that might be pertinent to my service. I am aware that the practice of laser is not an exact science and I acknowledge that no guarantees have been made to me as to the result of my service.

I understand that photographs will be taken to verify my service and these images will be stored in a secure manner and are for verification purposes only. I understand that a representative may come to me and request to use my photograph. I will either willingly agree or disagree to this request.

I acknowledge that I received a copy of this consent form.

SIGNATURE

DATE