

Name: _____

Date of Birth: ___/___/_____

Email: _____

Ethnic Background, please include all nationalities:

Address: _____ Apt# _____ City: _____

State: _____ Zip: _____ Home Phone: () _____ Cell: () _____

Occupation: _____ If we call you at home, do you want confidentiality?

May we call you at work? No Yes

If Yes, my work number is () _____

Emergency Contact: Name _____ Phone () _____ Relationship _____

Who may we thank for referring you? _____

Procedure(s) desired: Brows Eyeliner Lips Camouflage Areola Complex Correction

List all medications you are **presently** taking:

Name of drug	Mg. or mcg	How many ea. day	Why it was prescribed to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all medications you took **in the last six months** that you are no longer taking:

Name of drug	Mg. or mcg	How many ea. day	Why it was prescribed to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Practitioner Signature: _____ Date: ___/___/_____

Do you have? (check all that apply)

- Fever Blisters/Cold Sores (Ever, even one time)
- Glaucoma or other eye disease/disorder
- Grave's Disease
- Heart Disease
- Shingles History/Recent Shingles Shot
- Mitral Valve Prolapse
- Valve Implants
- Pacemaker
- Stents
- Diabetes requiring insulin
- Problems with healing
- Keloids
- Seizures
- Bell's Palsy - Active or in Flare-ups?

- Dermatol _____
- Hemophilia or Clotting _____
- Pre-existing nerve damage
- Tattoos: Colors you are sun sensitive to:

- Trichotillomania (pulling of hair, brows, lashes)
- Alopecia Totalis or Areata
- Allergies: _____

Are you? (check all that apply)

- Pregnant
- Planning Cosmetic If so, what & when?

- Currently under the care of a physician Describe

Do you practice outdoor activities? Circle all that apply:

- | | |
|-----------|---------|
| Tennis | Skiing |
| Golf | Walking |
| Gardening | Boating |
| Swimming | Other |

Client Name: _____
Practitioner Signature: _____
Date: ___ / ___ / _____

Do you use? (check all that apply)

- Accutane (currently or within the past year)
- Antibiotics prior to dental procedures
- Steroids
- Retin-A, Glycolic Acid, Vitamin C or other Exfoliants
- Tanning Beds
- Eyebrow Tinting
- Eyelash Tinting
- Latisse
- Botox When _____
- Chemical Peels When _____
- Chemotherapy or Prophylactic dose of Chemotherapy
- Blood Thinners

Have you had? (check all that apply)

- Fever Blisters/Cold Sores (Ever, even one time)
- Eye Infections (Are you prone to them)
- Vision Correction Procedure (Lasik, RK) within the past 3 months
- Heart Attack - When? _____
- Joint Replacement, Organ Transplant
- Eye Trauma
- Seizures
- Fainting Spells
- Hepatitis - What Type: _____
- Hepatitis Test - When? _____
- Fat Transfer Injections - If yes, where?

- Gore-Tex Implants - If yes, where?

- Aesthetic or Cosmetic Procedures
If yes, where? _____
- Laser Treatments
What type & why? _____

Physician's Name: _____
Address: _____
Phone: _____
Other Specialty: _____

Informed Consent TO PROCEDURE



1. Are you pregnant or nursing?

Yes [] No []

Initial

2. I understand the initial procedure is a two-part process where a touch up procedure is required 6-12 weeks after my first visit. _____

3. I have received, reviewed, and understand the pre-procedural instructions as given to me and agree to follow them. _____

4. Depending on the procedure(s), which I select, I accept responsibility for determining the shape, and position of eyebrows, eyeliners, lipliner and/or full lip color. _____

5. I understand that the color selection and color results in all procedures are not an exact science. _____

6. I understand that positioning of my procedures can be affected if I have elected or wish to elect cosmetic surgery, Botox, Restalyne or any other cosmetic filler and I assume this responsibility. _____

7. I am aware that if I am to receive an MRI after the procedure, I must tell the Radiologist that I have iron oxide Permanent cosmetics. _____

8. If I am a contact lens wearer, I realize I should not wear my contacts the day of my eyeliner procedure. _____

9. I understand that this procedure will fade over time and this fading can alter the original pigment color which determines it is time for a touch-up visit. _____

10. I realize this is an elective cosmetic procedure and is not medically necessary. _____

11. I have pre-medicated where advised based upon the medical history I provided. _____

12. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling. _____

13. Although rare, Fever blisters may occur regardless of pre-medication. _____

14. I understand that many lasers & IPL's (Intense Pulse Lights) including those used for hair removal, anti-aging, Photo Facials, removal of lines, can turn permanent make up dark or even black. I agree to inform my esthetician or anyone operating such I have permanent make up. _____

15. I give my consent for the practitioner to confer with my physicians for medical information required for the safety of my procedures. _____

16. I agree to accompany my practitioner to the emergency room in the event they were to be accidentally stuck with my needle and take a blood test for their safety & disclose all test results to my practitioner. _____

17. I am aware that if an infection occurs after I have received Permanent Cosmetics to see with my primary Physician or an emergency room, immediately _____

18. I understand there are no refunds on procedures. _____

ACCEPTANCE: Please read all questions thoroughly before signing!!

I have read and understand these risks listed above and they have been explained to me. I certify that the information in the above questionnaire is accurate and my questions have been answered.

Signature of Client X: _____

Practitioner Signature: _____ Date: ___/___/_____