PERMANENT MAKEUP
CLIENT INFORMATION FORM

APPOINTMENT DATE

APPOINTMENT TIME

FULL NAME

ADDRESS

CITY

STATE / PROVINCE

ZIP / POSTAL CODE

PHONE

EMAIL ADDRESS

DATE OF BIRTH (DD/MM/YYYY)

CURRENT AGE

EMAIL / NEWSLETTER

Occasionally we may send out emails or newsletters about upcoming discounts, promotions, contests, company information etc. If you would like to be added to the subscriber list please check "Yes" below. If you would like to opt out please check "No".

☐ YES! Sign me up!

☐ No, thank you.

We will use your e-mail address solely to provide information about our company. Your information will not be sold.

Have you ever had a cosmetic tattoo or permanent makeup procedure before? yes no
If yes, when was your last procedure? _____

What would you like to improve/change about the area?
Consider shape, color, density, thickness...

Do you have moles/raised areas in or around the treatment area? yes no

Do you have or have you had a piercing in treatment area? yes no

FEMALE CLIENTS ONLY

Are you, or is it possible you may be pregnant? yes no

Are you currently breast feeding? yes no

CLIENT INFORMATION Continued

For a more effective, personalized treatment, please be as accurate as possible when filling out the following information

MEDICAL QUESTIONNAIRE

Are you prone to keloid scarring, hypertrophic scarring, or any other form of excessive scarring condition?	◯ Yes	◯ No
Have you taken a medication containing Isotretinoin (e.g. Roaccutane) during the previous 12 months?	◯ Yes	◯ No
Do you have, or do you think it is possible you may have a Blood Borne Communicable Disease? e.g. Hepatitis C Virus (HBC), Hepatitis B Virus (HBC), Human Immunodeficiency Virus (HIV)	◯ Yes	◯ No
Do you currently have any other form of communicable disease, or infection? e.g. respiratory infection, gastrointestinal infection, skin infection, ear or eye infection, bacterial, fungal or viral infection etc.	◯ Yes	◯ No
Do you have Diabetes, currently on any form of immuno suppressant therapy, or have any other condition that may cause delayed healing?	◯ Yes	◯ No
Have you ever had a Herpes Simplex Type I infection (also called cold sores/fever blisters)?	◯ Yes	◯ No
Do you have any Hypersensitivity, Auto-Immune Disorder, or Allergic Conditions?	◯ Yes	◯ No
Do you have a known allergy or sensitivity to any topical or local anesthetics including dental anesthetics?	◯ Yes	◯ No
Have you ever taken a medication containing Bisphosphonate/Diphosphonate? (e.g. fosamax, alendronate)	◯ Yes	◯ No
Do you have any form of bleeding disorder, or are you taking any anticoagulants (blood thinners)?	◯ Yes	◯ No
Have you had any form of Cosmetic or Surgical Procedure, Radiotherapy, or Chemotherapy at any time during the past 6 months?	◯ Yes	◯ No
Do you suffer from any form of hyper-pigmentation skin conditions?	◯ Yes	◯ No
Do you suffer with fainting, blackouts, or seizures?	◯ Yes	◯ No
Do you have a cardiac pacemaker, Implanted Cardioverter Defibrillator (ICD), have a serious heart condition, or abnormal blood pressure?	◯ Yes	◯ No
Do you have any form of acute or chronic eye condition?	◯ Yes	◯ No
Are you prone to developing Telangiectasia? (sometimes referred to as spider veins)	◯ Yes	◯ No

CLIENT INFORMATION Continued

SPECIAL PRECAUTIONS

Do you suffer from allergies? ◯ yes ◯ no
If yes, please specify _____

_____

_____

Are you currently taking any medications, herbs, vitamins? ◯ yes ◯ no
If yes, please specify

_____

_____

_____

Do you have an allergy or sensitivity to latex/rubber? ◯ yes ◯ no

Do you smoke? ◯ yes ◯ no

Do you have a known allergy or sensitivity to any ingredients within tattoo pigments or needles, regular makeup, any preservatives, hair dyes, or other dyes? ◯ yes ◯ no

Do you have a known allergy or sensitivity to any ingredients in tattoo aftercare creams, antiseptics, lanolin, or petrolatum (petroleum jelly)? ◯ yes ◯ no

Have you used any eyelash or eyebrow growth serums / creams or any eye drops that may contain prostaglandin analogues in the past 4 weeks? ◯ yes ◯ no

Do you wear contacts? ◯ yes ◯ no

Is there any additional information about you that we should know before starting your treatment?

_____

_____

_____

_____

Please read the following statements carefully. Permanent Makeup is a way of cosmetic tattooing, intended to last an average of 12-36 months. On rare occasions, the pigment may migrate under the skin. The procedure of Permanent Makeup may be uncomfortable. Although extremely rare, there might be an immediate or delayed allergic reaction to pigment. A negative patch test result does not guarantee that you will not develop an allergic reaction after the full procedure. Allergic reactions to anesthetic can occur. Permanent cosmetics cannot be performed if you are pregnant or nursing, or anyone under the age of 18. Infections can occur if aftercare instructions are not followed correctly. There may be swelling and redness following the procedure. You may experience minor bleeding. If you have an MRI scan within 3 months after the permanent makeup procedure, you should notify/discuss with your doctor. Possible scarring may occur.

I have received after care information and I'm fully aware of the after care procedures. I fully understand the information provided above & confirm that all information provided by me is correct and truthful.

_____ _____

Client Name (please print) Client Signature

_____ _____

Day/Month/Year Cosmetic Professional

INFORMED CONSENT FOR PERMANENT MAKEUP

I_____ am over the age of 18, am not under the influence of drugs or alcohol, am not pregnant or nursing and desire to receive the indicated semi-permanent pigmentation procedure. The general nature of cosmetic micro-pigmentation, as well as the specific procedure to be performed, has been explained to me.

_____ If an unforeseen condition arises in the course of the procedure, I authorize my therapist to use his/her professional judgment to decide what he/she feels is necessary under the given circumstances. I accept the responsibility for determining the color, shape and position of the Permanent Makeup procedure as agreed during consultation. I fully understand and accept that non-toxic pigments are used during the procedure and that the result achieved may fade over a period of 1-3 years. Even once the color fades, pigment itself may stay in the skin indefinitely.

_____ I have been informed that the highest standards of hygiene are met and that sterile, disposable needles and pigment containers are used for each individual client, procedure and visit.

_____ I understand and accept that each procedure is a process requiring multiple applications of pigment to achieve desired results and that 100% success cannot be guaranteed during the first procedure. I understand that I may have to return for a repeat procedure.

_____ The result of the procedure can be affected by the following: medication, skin characteristics (dry, oily, sun-damaged thick or thin skin type), personal pH balance of your skin, alcohol intake and smoking, post procedure after care.

_____ Upon completion of the procedure there might be swelling and redness of the skin, which will subside within 1-4 days. In some cases, bruising may occur. You may resume normal activities following the procedure, however, using cosmetics, excessive perspiration and exposure to the sun should be limited until the skin has fully healed. Please see after care instructions for more details. The procedure results will look acceptable for you to appear in public without additional make-up.

_____ I have been advised that the true color will be seen 6 weeks after each procedure, and that the pigment may vary according to skin tones, skin type, age and skin condition. I understand that some skin types accept pigment more readily and no guarantee on exact color can be given.

_____ To my knowledge, I do not have any physical, mental or medical impairment or disability that might affect my well being as a direct or indirect result of my decision to have the procedure done at this time.

_____ I agree to follow all pre-procedure and post-procedure instructions as provided and explained to me by the technician. Failure to do so may jeopardize my chances for a successful procedure.

_____ I can confirm that I have received a copy of after care details.

INFORMED CONSENT Continued

_____ I have been informed of the nature, risks, and possible complications and consequences of permanent skin pigmentation. I understand the permanent skin pigmentation procedure carries with it known and unknown complications and consequences associated with this type of cosmetic procedure, including but not limited to: infection, scarring, inconsistent color, and spreading, fanning or fading of pigments. I understand the actual color of the pigment may be modified slightly, due to the tone and color of my skin.

_____ I fully understand this is a tattoo process and therefore not an exact science but an art. I request the semi- permanent skin pigmentation procedure(s) and accept the permanence of this procedure as well as the possible complications and consequences of the said procedure.

There is a possibility of an allergic reaction to numbing agent and/or pigments. A patch test is offered however it does not ensure a client will not have an allergic reaction. If waived, I release the technician from liability if I develop an allergic reaction to the pigment. Initial one or the other, not both: I consent_____ to the patch test OR I waive _____the patch test

_____ I understand that if I have any skin treatments, injectables, laser hair removal, plastic surgery or other skin altering procedures, it may result in adverse changes to my permanent makeup procedure. I acknowledge some of these potential adverse changes may not be correctable.

_____ I certify that I have read and initialed the above paragraphs and have had explained to my understanding the consent and procedure permit. I accept full responsibility for the decision to have this cosmetic semi-permanent pigmentation work done.

_____ I give _____ permission to perform my Permanent Makeup procedure.

Client Name (please print)

Client Signature

Day/Month/Year

Cosmetic Professional

DISCLOSURE & RELEASE FORM

I UNDERSTAND THE FOLLOWING COMPLETELY: (PLEASE INITIAL EACH STATEMENT)

_____ Permanent Makeup can last 12-36 months depending on how my skin reacts to the procedure. There may be fading and/or discoloration. The result may not be what I expected to receive. I understand this is a semi-permanent makeup procedure that may take numerous follow-ups and touch ups to get a desired result.

_____ There is no warranty or guarantee made to me as a result of this procedure and the final result cannot be guaranteed. There are no refunds for this procedure, as results will vary and individual results are not guaranteed.

_____ I have seen and agree with the pre-drawn shape that my artist created. I understand that this is a guideline for the shape and size of my brow design and it may vary slightly once the procedure is done.

_____ There may be risks and hazard related to performing this procedure.

_____ There may be discomfort and pain during this procedure.

_____ There is a possibility of bleeding, swelling, redness and allergic reactions to pigments.

_____ Permanent Makeup is considered semi-permanent and can/will fade over time.

_____ Permanent Makeup, though semi-permanent, may last permanently and may not fade.

_____ Surgical procedures may be required to remove pigment from skin. These procedures may cause scarring and permanent damage to the skin.

_____ Final results cannot be determined until the area is completely healed at 4 to 6 weeks.

_____ I understand that permanent and semi-permanent makeup procedures cannot be guaranteed and results cannot be predicted, as there are many variables that contribute to the final result, such as aftercare, skin type, lifestyle, etc.

_____ I have received post care instructions and will follow them to ensure results of my procedure are satisfactory.

_____ I am NOT pregnant.

_____ I am NOT under the influence of drugs and/or alcohol or any other mind altering substance.

_____ I fully understand the procedure and give permission to my technician to perform the service of Permanent Makeup and all procedure and steps involved.

_____ I have truthfully filled out the consent form and have informed my technician of all medications I have taken.

_____ I release _____ of all claims and injury, seen or unseen that may occur as a result of this procedure.

Client Name (please print)	Client Signature
Day/Month/Year	Cosmetic Professional