9425 Olde 8 Rd #2
Northfield Center, OH 44067
(216) 200-8071

Today's Date: ___/___/20___

Client Info:

Name: _____ Date of Birth: ___/___/___ Email: _____

Ethnic Background *(Please include all nationalities)*: _____

Address: _____ Apt. #: ____ Home Phone: (____) ____-_____

City: _____ State: ____ Zip Code: _____ Cell Phone: (____) ____-_____

Occupation: _____

Emergency Contact Information:

Name: _____ Phone: (____)____-_____ Relationship: _____

Who may we thank for referring you? ◉ Facebook ○ Instagram ○ Google ○ Other: _____

I was referred by: _____

Procedure(s) desired: ☐ Brows ☐ Lips ☐ Beauty Mark ☐ Coverup/Correction ☐ Permanent Eyeliner

☐ Scar Camouflage ☐ Inkless Stretchmark/Stretchmark Camouflage

List all medications you are presently taking

Name of Drug	mg or mcg	Amount/Day	Why it was prescribed to you?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all medications you took <u>in the last six months</u> that you are no longer taking

Name of Drug	mg or mcg	Amount/Day	Why it was prescribed to you?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Practitioner Signature: _____ **Date:** ___/___/20 ___

GENERAL MEDICAL

Client Name: _____

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
- ☐ Dermatological Disorder
  - *If so, what?* _____
  - *Active or in Flare-ups?* _____
- ☐ Hemophilia or Clotting Disorder
- ☐ Autoimmune Disorder
- ☐ Pre-existing nerve damage
- ☐ Tattoos: Colors you are sun sensitive to:
  - _____
- ☐ Trichotillomania (pulling of hair, brows, lashes)
- ☐ Alopecia Totalis or Areata
- ☐ Allergies
  - *List:*

    _____

ARE YOU? (CHECK ALL THAT APPLY)

- ☐ Pregnant
- ☐ Planning cosmetic surgery
  - *If so, what & when?*

    _____
- ☐ Currently under the care of a physician
  - *Describe:*

    _____

DO YOU PRACTICE OUTDOOR ACTIVITIES? (CHECK ALL THAT APPLY)

- ☐ Tennis
- ☐ Golf
- ☐ Gardening
- ☐ Boating
- ☐ Swimming
- ☐ Skiing
- ☐ Walking
- ☐ Other: _____

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: (____) ____-_____ **Specialty:** _____

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Signature of Practitioner: _____

INFORMED CONSENT TO PROCEDURE

(PLEASE READ ALL QUESTIONS THOROUGHLY BEFORE SIGNING)

	INITIAL
Are you pregnant or nursing? ☐ Yes ☐ No	
I absolutely understand and accept that such procedure is a process, often requiring multiple applications of color to achieve desirable results and the 100% success cannot be guaranteed.	
I have received, reviewed and understand the pre-procedural instructions as given to me and agree to follow them.	
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.	
I understand that the color selection and color results in all procedures are not an exact science.	
I understand that positioning of my procedures can be affected if I have elected or wish to elect cosmetic surgery, Botox, or Restalyne, and I assume this responsibility.	
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.	
If I am a lens wearer, I realize that I must keep my lenses out the day of an **eyeliner procedure**.	
I understand that this procedure *will fade* and this fading can alter the original pigment color and that this determines that it is a time for a touch-up visit.	
I realize this is an elective cosmetic procedure and is not medically necessary.	
It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment.	
I understand that many lasers & IPL's (Intense Pulse Lights) including those used for hair removal, anti-aging, Photo Facials, removal of lines may or will turn permanent make up dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent makeup.	
I give my consent to **BE YOU COSMETIC TATTOO LLC.** to confer with my physicians for medical information required for the safety of my procedures.	
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.	
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***.	
I have been quoted the cost of today's appointment and the cost of (1) 6-8 week touch-up appointment.	
I understand that there is a small possibility of an allergic reaction and that I may elect to take a 48hr patch test prior to getting this procedure.	

ACCEPTANCE:

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: _____ **Date Signed:** ___/___/20___

Signature of Practitioner: _____ **Date Signed:** ___/___/20___

BE YOU COSMETIC TATTOO LLC.
9425 Olde 8 Rd #2
Northfield Center, OH 44067
(216) 800-8474

PHOTOGRAPH AND PUBLICITY RELEASE FORM

We would like your permission to use photos and/or videos for advertising. For example: portfolios, social media, and print ads, etc. Your consent is necessary regarding this. Please indicate below if you would like your photos used or not used in advertising.

☐ YES, feel free to use them.
☐ YES, you can use my photos/video, but please conceal my identity in the photo/video.
☐ **NO, please do not use them.**

We also like to tag our clients in photos used on our Instagram or Facebook profile! Please indicate if you'd like to allow this or not below.

☐ YES, please tag me on Instagram/Facebook. My IG is @_____
☐ **NO, please do not tag me on social media.**

I have read and understood this consent and release.

_____ _____
Signature Date

_____
Print Name

COVID-19 Liability Release Waiver

The World Health Organization has declared the novel Coronavirus (COVID-19) a worldwide pandemic. Due to its capacity to transmit from person-to-person through respiratory droplets, the government has set recommendations, guidelines, and some prohibitions which **Be You Cosmetic Tattoo, LLC** ("the Organization") adheres to comply.

In consideration of my participation in the foregoing, the undersigned acknowledge and agree to the following:

☐ **I have not experienced symptoms of fever, fatigue, difficulty in breathing, or dry cough or exhibiting any other symptoms relating to COVID-19 or any communicable disease within the last 14 days.**

☐ **I have not, nor any member(s) of my household, traveled by sea or by air, internationally within the past 30 days.**

☐ **I did not, nor any member of my household, visit any any area within the United States that was reported to be highly affected by COVID-19, in the last 30 days.**

☐ **I have not been, nor any member(s) of my household, diagnosed to be infected of COVID-19 virus within the last 30 days.**

☐ **I am fully and personally responsible for my own safety and actions while and during participation and I recognize that I may be at risk of contracting COVID-19.**

☐ **With full knowledge of the risks involved, I hereby release, waive, discharge the Organization, its board, officers, independent contractors, affiliates, employees, representatives, successors, and assigns from any and all liabilities, claims, demands, actions, and causes of action whatsoever, directly or indirectly arising out of or related to any loss, damage, injury, or death, that may be sustained by me related to COVID-19 while participating in any activity while in, on, or around the premises or while using the facilities that may lead to unintentional exposure or harm due to COVID-19.**

☐ **I agree to indemnify, defend, and hold harmless the Organization from and against any and all costs, expenses, damages, lawsuits, and/or liabilities or claims arising whether directly or indirectly from or related to any and all claims made by or against any of the released party due to injury, loss, or death from or related to COVID-19.**

By signing below I acknowledge that I have read this Liability Release Waiver and understand its contents; that I am at least eighteen (18) years old and fully competent to give my consent; That I have been sufficiently informed of the risks involved and give my voluntary consent in signing it as my own free act and deed; that I give my voluntary consent in signing this Liability Release Waiver as my own free act and deed with full intention to be bound by the same, and free from any inducement or representation.

Signature: _____ Date ___/___/20___

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BE YOU COSMETIC TATTOO
216-800-8474

Client Name: _____ **Date:** /. /20___

Procedure Type:

Tool/Product	Brand	Lot Number	Expiration
Needle(s)			
Topical Anesthetic(s)			
Pigment(s)			
Other Product(s)			

PROCEDURE NOTES:

_____

_____

_____

_____

Practitioner Signature: _____ **Date:** ___/___/20___