CLIENT INFORMATION SHEET

NAME_____ Date of Birth:_____

ADDRESS_____

PHONE (Day)_____ Night_____
May we contact you at these numbers if necessary? ☐Yes ☐No

PROCEDURES DESIRED:
☐Eyeliner ☐Eyebrows ☐Lipline ☐Full Lip Color ☐Nipples
☐Beauty Mark ☐Skin Repigmentation ☐Other_____
If you selected "other" please explain:_____

Have you **ever** had a cold sore? ☐Yes ☐No If yes, you must contact your physician for a prescription of ZOVIRAX capsules, an antibiotic which prevents cold sores.

I have read the above information regarding ZOVIRAX and understand its use is mandatory if I desire lipline or full lip color procedures.

*Signed:_____(Client)

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Who referred you:_____
Are you currently under the care of a physician? ☐Yes ☐No

If so, why?_____

Physician's name:_____

Do you take antibiotics when going to the dentist? ☐Yes ☐No If Yes, Why?_____

Do you suffer from: ☐Allergies ☐Moles or freckles at site of tattoo ☐Hepatitis
☐Heart Problems ☐Hemophilia ☐Diabetes ☐Skin Problems ☐Scarring (Keloids) Eye
☐Problems ☐Epilepsy ☐Other: Please explain:_____

Are you presently taking any medication which thins the blood? ☐Yes ☐No

Are you taking other medications? ☐Yes ☐No If yes, explain: _____

Are you pregnant or nursing? ☐Yes ☐No

Do you wear contact lenses? ☐Yes ☐No

I understand that if I fail to cancel my appointment within 24 hours, there will be a charge of $_____

*Signed:_____(Client) Date:_____