CLIENT NAME: _____

LITTLE LASH BOUTIQUE

29 Deer Park Avenue
Babylon, New York 11702

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: _____

If we call you at home, do you want confidentiality? Please circle one: Yes No

May we call you at work? Yes No If *yes*, my work number is (____) ____-_____

Emergency Contact Information:

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

Who may we thank for referring you? _____

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

Have you, or do you suffer(ed) from Body Dysmorphic Disorder, Obsessive Compulsive Disorder, Paranoia, or any other related ailment? Please circle YES or NO

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?

_____

_____

_____

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

CLIENT NAME: _____

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? (CIRCLE ALL THAT APPLY)

Tennis Swimming
Golf Skiing
Gardening Walking
Boating 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'sName: _____
Address: _____
Phone:(____) ____-_____ **Specialty:** _____
Signature of Practitioner: _____
Date: ___/___/20___

CLIENT NAME: _____

INFORMED CONSENT TO PROCEDURE

(PLEASE READ ALL QUESTIONS THOROUGHLY BEFORE SIGNING)

1. Are you pregnant or nursing? Yes No _____

PLEASE INITIAL:

2. 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. _____

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, or Restylane, 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 lens wearer, I realize that I must keep my lenses out the day of an **eyeliner procedure**. _____

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

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

11. 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. _____

12. 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 makeup dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent make up. _____

13. I give my consent to **Little Lash Boutique** to confer with my physicians for medical information required for the safety of my procedures. _____

CLIENT NAME: _____

14. 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. _____

15. 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***. _____

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___

Please give your State issued license to our receptionist to make a copy for the Department of Health

LLB
LITTLE LASH BOUTIQUE

CLIENT NAME: _____

Appendix D

CONSENT FOR BODY ART PROCEDURES

THE SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES DOES NOT ENDORSE OR RECOMMEND BODY ART PROCEDURES IN ANY FORM. This includes, but not limited to Tattooing, Body Piercing, Branding, Scarification, Cosmetic Tattooing, Permanent Makeup, Micropigmentation and Dermopigmentation.

Date: _____

I, _____ **, consent to the following body art**
(Print Name of Customer)

procedure: _____ **performed by** _____ **at**
(Name of Body Artist)

_____.
(Name of Body Art Establishment & Town/Hamlet)

The aforementioned Body Artist has fully explained to me the nature of the procedure(s) and has informed me of the potential complications and risks including, but not limited to: bleeding, pain, swelling, infection, prolonged healing, scarring, nerve damage, fainting and death.

I am aware that Body Art Procedures are invasive and may involve possible health risks, especially for people with certain underlying medical conditions. I am also aware that I should consult with my physician prior to receiving any Body Art Procedure. If I experience an adverse effect during the healing period related to the Body Art Procedure I received, I have been advised to seek medical care as soon as possible and advise the Body Artist and/or the Body Art Establishment where I received the procedure.

*NOTE: It is possible to become infected with Hepatitis B, Hepatitis C, HIV or any other blood-borne disease with any procedure that involves exposure to blood products or instruments contaminated with blood products. In addition, an individual cannot donate blood for 12 months after having any body art procedure.

I have been provided with a copy of Appendix A, Aftercare Instructions, for my particular Body Art Procedure, and, if it's a Body Piercing, a copy of Appendix E relating to healing periods. I have also had the opportunity to have any questions about the procedure answered.

Client Signature: _____

Parent/Guardian signature (for Body Piercing of Minors only): _____

State of New York)
ss:
County of Suffolk)

On this ____ day of _____, 20___, before me personally appeared _____ _____, to me known to be the same person described herein and who executed the foregoing instrument and acknowledged that s/he executed the same.

_____
Notary Public, State of New York