



CLIENT INFORMATION

Name: _____ Date: ____ / ____ / ____

Phone: (Cell) _____ (Home or Work) _____

Email: _____

If we call your home, do you want confidentiality? No Yes

Address: _____

Occupation: _____ Date of Birth: ____ / ____ / ____

Emergency Contact: Name/Relationship _____ / _____

Phone: _____

Under 18 yrs. old, parent/guardian must consent prior & attend the procedure.

Parent/Guardian: _____ Phone: _____

Who may we thank for referring you? _____

PROCEDURE(S) DESIRED

- BROWS (circle all that apply: MICROBLADING / POWDER)
- EYELINER (circle all that apply: TOP / BOTTOM / WINGED) Preferred Color: _____
- LIPS (circle all that apply: LIPLINER / SHADING) Preferred Color: _____
- CAMOUFLAGE Explain: _____
- AREOLA COMPLEX
- SCALP MICROPIGMENTATION (area _____)
- CORRECION Explain: _____

I would like a **PATCH TEST** done to ensure I am not going to have an allergic reaction to the pigments or topical anesthetics. There is a 5-7 day waiting period after patch test, before procedure.

Take Waive

PHOTOGRAPHY RELEASE

Your treatment will be documented with photos/videos to, visually, monitor progress of results and keep accurate, individual records.

I give full consent for all photographs/footage captured before, during, and after treatment to be used by **VAULT COSMETICS @ Prodigio** for advertising & educational purposes in any medium now known or later developed. I acknowledge I will not receive compensation for use of such materials. I understand that all materials will remain the property of Prodigio Day Spa.

Signature _____ Date ____ / ____ / ____

MEDICAL HISTORY

Check all that apply and provide last treatment dates where applicable

<input type="checkbox"/> MRSA ___/___/___	<input type="checkbox"/> Hepatitis (A,B,C,D)	<input type="checkbox"/> Radiation ___/___/___
<input type="checkbox"/> Type I Diabetes	<input type="checkbox"/> Keloid Scarring	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Type II Diabetes	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Abnormal Heart Condition
<input type="checkbox"/> Eczema/Psoriasis	<input type="checkbox"/> Rosacea	<input type="checkbox"/> Chemical Peel ___/___/___
<input type="checkbox"/> Oily Skin	<input type="checkbox"/> Shingles ___/___/___	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Graves' Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Lasik surgery ___/___/___	<input type="checkbox"/> Diagnosed Mental Disorder	<input type="checkbox"/> Cold Sores ___/___/___
<input type="checkbox"/> Cold/Flu ___/___/___	<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> Difficulty Numbing
<input type="checkbox"/> Cancer ___/___/___	<input type="checkbox"/> Chemotherapy ___/___/___	<input type="checkbox"/> Stents
<input type="checkbox"/> Botox/Dysport ___/___/___	<input type="checkbox"/> Tattoo removal ___/___/___	<input type="checkbox"/> Joint Replacement ___/___/___
<input type="checkbox"/> Trichotillomania (voluntary pulling out brows / lashes)	<input type="checkbox"/> Fillers - (Juvederm, Restalyne, Voluma, Sculptra, Silk, etc.) ___/___/___	<input type="checkbox"/> Use of Retinols / Retinoids (Vitamin A) ___/___/___
<input type="checkbox"/> Alopecia Totalis or Areata	<input type="checkbox"/> Lash growth serum ___/___/___	<input type="checkbox"/> Face/Brow/Forehead Lift (circle) ___/___/___
<input type="checkbox"/> Metal Rods	<input type="checkbox"/> Laser treatment ___/___/___	<input type="checkbox"/> Dental Implant ___/___/___
<input type="checkbox"/> Organ Transplant ___/___/___	<input type="checkbox"/> Tanning (booth or sun) ___/___/___	<input type="checkbox"/> Brow/Lash Tint ___/___/___
<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Alopecia Totalis or Areata	<input type="checkbox"/> Use of Accutane ___/___/___
<input type="checkbox"/> Use of Blood Thinners	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Nursing

**MEDICATIONS PRESENTLY taking & in the LAST 6 MONTHS have taken & purpose
(include vitamins/supplements/antibiotics)**

ALLERGIES

All above information is true and accurate to the best of my knowledge.

Signature _____ Date ___/___/___

STATEMENT OF CONSENT AND RECITALS (please initial)

____ I understand/accept such procedure is a process, often requiring multiple applications of color to achieve desirable results and 100% success cannot be guaranteed.

____ I understand that payment today includes 2 appointments, 5-6 weeks apart. Additional sessions will require an additional fee per session.

____ I accept responsibility for determining the shape & position of eyebrows, eyeliner, lip liner, freckles/beauty mark(s) and/or full lip color.

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

____ I understand that implanted pigment color can change and/or fade over time. In order to keep permanent cosmetics looking fresh, I will need to maintain the color and shape with future maintenance appts.

____ I acknowledge that permanent cosmetic procedures can involve inherent risks such as infection, poor color retention, hyperpigmentation, minor and temporary bleeding, bruising, redness, swelling, fever blisters (lip area following lip procedure), fading or loss of pigment.

____ I understand that the positioning of my permanent cosmetics can be affected if I elect to have cosmetic surgery, Botox or Fillers (injectables). I assume this responsibility.

STATEMENT OF CONSENT AND RECITALS (continued)

___ I am aware that if I am to receive an MRI after my permanent cosmetic procedure, I must tell the radiologist that I have iron oxide permanent cosmetics. This won't effect the MRI result. It's just not as obvious as traditional body tattoos.

___ If I am a lens wearer, I realize that I must keep my lenses out the day of an eyeliner procedure.

___ I understand this is an elective cosmetic procedure and is not medically necessary.

___ I understand that many lasers & IPL's (Intense Pulse Light), including those used for hair removal & anti-aging facials, may or will turn permanent cosmetics dark or even black. I agree to inform my technician that I have permanent makeup.

___ I give my consent to VAULT COSMETICS @ *Prodigo* to confer with my physician for medical information required for the safety of my procedures.

___ I agree to accompany my practitioner to the emergency room to take a blood test in the event they or I were accidentally stuck with a needle. It would be for our safety. I agree to disclose all test results to my practitioner.

___ If an infection occurs after I have received permanent cosmetics, I will seek medical attention from my primary physician or emergency room, *immediately*, then contact my technician.

___ I understand that exfoliating skincare, chemical or physical, must not be used on the area where the permanent cosmetic procedure occurred. They will alter the color or make it fade more quickly.

___ I understand that excessive sun, tanning booths/beds, and certain medications can alter the color or make it fade faster than desired. Individual results vary.

___ I understand that 2 sessions, 5-6 weeks apart, are required for permanent cosmetics on virgin skin. These 2 sessions are included in the quoted price. I acknowledge there will be a charge for any sessions after that to achieve the desired result.

___ Aftercare instructions have been explained and a written copy has been given to me.

****Please read all statements thoroughly before signing****

ACCEPTANCE:

I have read and understand all risks involved for my permanent cosmetic procedure. I have been given an opportunity to ask questions regarding these risks. And, all my questions have been answered. I certify that the information I have been asked for is accurate.

Print _____

Sign _____ **Date** ___/___/___