# PERMANENT MAKEUP
## CLIENT INFORMATION FORM

Appointment Day & Time:

MM DD YYYY | HH:MM

Please fill out this form on your first appointment.
Your answers will better help us to meet your needs and ensure that you have a happy and satisfying experience.

Full Name

Address

Zip / Postal Code

State / Province

City

Date of Birth

Phone

Emergency Contact Phone

Email

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 about your eyebrows/lips/eyes/scalp/areola?
(Consider shape, color, density, thickness)

Do you have moles/rasied areas in or around the brow area? ☐ Yes ☐ No

Do you have or have had a piercing in the brow area? ☐ Yes ☐ No

Have you had a hair transplant for your eyebrows? ☐ Yes ☐ No

## FEMALE CLIENTS ONLY

Are you, or is it possible you may be pregnant? ☐ Yes ☐ No

Are you currently breast feeding? ☐ Yes ☐ No

# PERMANENT MAKEUP

## MEDICAL QUESTIONNAIRE

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

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? ☐ Yes ☐ No
e.g. Hepatitis C Virus (HBC), Hepatitis B Virus (HBC), Human Immunodeficiency Virus (HIV)

Do you currently have any other form of communicable disease, or infection? ☐ Yes ☐ No
e.g. Respiratory infection, gastrointestinal infection, skin infection, ear or eye infection, bacterial, fungal or viral infection, etc.

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

Do you suffer from allergies? If yes, please specify: ☐ Yes ☐ No

Are you currently taking any medications, herbs, vitamins? If yes, please specify: ☐ Yes ☐ No

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.**

Semi-Permanent Makeup procedures are a way of cosmetic tattooing, intended to be semi-permanent lasting 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 microblading 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 (Printed Name)

Technician Name

Client Signature

Technician Signature

Date

Date

For Technician Use Only - Notes:

# PERMANENT MAKEUP

## INFORMED CONSENT

I hereby consent to and authorize my technician _____ to perform my permnanet makeup procedure.

(technician)

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 permanent makeup procedure. The general nature of cosmetic micro-pigmentation, as well as the specific procedure to be performed, has been explained to me.

**Please read and initial all lines:**

- [ ] If an unforeseen condition arises in the course of the procedure, I authorize my technician 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 semi-permanent 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 on.

- [ ] 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.

- [ ] 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 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.

- [ ] 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 semi-permanent 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.

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.

☐ **I acknowledge that no guarantees have been made to me concerning the results of this procedure.**

☐ I accept full responsibility for determining the color, shape and position of the semi-permanent procedure that will be applied. Once the shape is approved and the pigment is implanted in the skin, I will not be able to change it.

☐ I consent to the patch test **OR** ☐ I waive the patch test

☐ I understand the actual color of the pigment may vary slightly due to the tone and color of my skin.

☐ When you leave our office, the strokes are intact. How your body heals the treated area is 100% out of the control of the technician. This is 100% your bodies job. Even when following the aftercare fading, blurring or poor retention can still happen depending on your skin type & lifestyle. This is NOT the fault of the technician.

☐ If you have had tattoo removal prior to seeing the technician, due to scar tissue the pigment may not retain. Further procedures may not be an option and I understand there are NO REFUNDS and accept full responsibility and wish to proceed.

☐ If you choose to go with a darker color for your brows at your initial appt. and later decide that you want to go lighter (lighten hair) it will not be possible to lighten the color. Removal may be your only option.

☐ In the event of a CAT or MRI scan, please inform your physician of your Iron Oxide Permanent Cosmetics as some pulling or burning sensation (rare) may occur during the procedure.

☐ I understand that if I do not abide by the strict after care, I WILL ruin my results. The After Care is crucial for optimum pigment retention and results.

☐ Permanent Makeup is an ART, NOT a science. Client's results will vary from person to person and using a pencil or powder may or will still be needed. We have no control over your bodies healing process and each time a procedure is done, the pigment will have less retention due to scar tissue.

☐ Touch ups will not be done any sooner than the required time recommended by the technician.

☐ I acknowledge that the obtaining of Permanent Make-up procedure(s) is my choice alone, and I consent to the application of the procedure and accept the risks.

☐ Absolutely NO Refunds after services have been performed.

☐ I understand that at a certain point as the skin ages, PMU will no longer be performed.

Are you pregnant, nursing or trying (IVF) to get pregnant? ☐ Yes ☐ No ☐ Maybe

For the purposes of education or assistance, I consent to the admittance of authorized observers to the procedure(s).
**APPROVE _____ (initial) DECLINE _____ (initial)**

☐ **My technician can release me at any time from any future services if they feel policies or procedures are not followed.**

☐ I have read and fully understand the contents of each paragraph above. I acknowledge this is a legal & binding contract and that I have received no warranties or guarantees with respect to the benefits to be realized from or consequences of, the aforementioned procedure(s). I further acknowledge that at the time of signing this consent to this procedure(s), I was of sound mind and capable of making independent decisions for myself.

Client (Printed Name)

Client Signature

Date (Month/Day/Year)

Technician

# PERMANENT MAKEUP

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 brows are 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 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.
  (technician)

Client (Printed Name)

Client Signature

Date (Month/Day/Year)

Technician

# PHOTO/VIDEO CONSENT FORM

I, _____, hereby grant permission to the rights of my image, likeness and sound of my voice as recorded in audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published, or distributed. I waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

**PHOTOGRAPHIC, AUDIO, OR VIDEO RECORDINGS MAY BE USED FOR THE FOLLOWING PURPOSES:**

- Educational presentations or courses
- Informational presentations
- Online educational courses
- Educational videos
- Promotional materials

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the internet or in the public educational setting.

☐ I will be consulted about the use of the photographs or video recordings for any purpose other than those listed above.

☐ There is no time limited in the validity of this release nor is there any geographic limitation on where these materials may be distributed.

☐ This release applies to photographic, audio, or video recordings collected as part of the sessions listed on this document only.

**By signing this form, I acknowledge that I have completely read and fully understand the above release and agree. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.**

| Client (Printed Name) | Client Signature | Date |
| --- | --- | --- |
| | | |

# PRECAUTIONARY COVID-19

## LIABILITY RELEASE FORM

Due to the 2019 - 2020 pandemic of the coronavirus (COVID-19), we are taking extra precautions as we proceed with each client. We will be implementing additional sanitation and disinfecting practices. Please read, complete the following, and sign below.

**SYMPTOMS OF COVID-19 INCLUDE AND ARE NOT LIMITED TO:**

- FEVER
- FATIGUE
- SHORTNESS OF BREATH
- DRY COUGH
- SORE THROAT
- BODY ACHES / PAIN
- HEADACHE

**I, _____, AGREE TO THE FOLLOWING:**

_____ I agree to have my temperature taken and to reschedule my appointment if my temperature exceeds the normal range of 96 – 99 Degree Fahrenheit.

_____ I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced symptoms listed above within the last 14 days.

_____ I affirm that I, as well as all household members, have not traveled outside of the country, or to any known COVID-19 "hot spot" states in the last 30 days.

_____ I agree to wear a protective mask for the duration of my visit.

_____ I understand my technician will not be liable for any exposure to the virus or any other contagion during my visit.

_____ I affirm my procedure is elective and in no way medically necessary. I chose to be here on my own free will.

**My signature below indicates I agree to each of the above statements and release my technician and the business from any and all liability for the unintentional exposure to COVID-19 virus.**

Client Signature

Date

Your technician and all employees of this facility agree that they abide by these same standards and affirm the same. We also affirm that we have improved and expanded our sanitation protocols to more thoroughly prevent the spread of COVID-19 and other communicable conditions.

FOR PROFESSIONAL USE ONLY

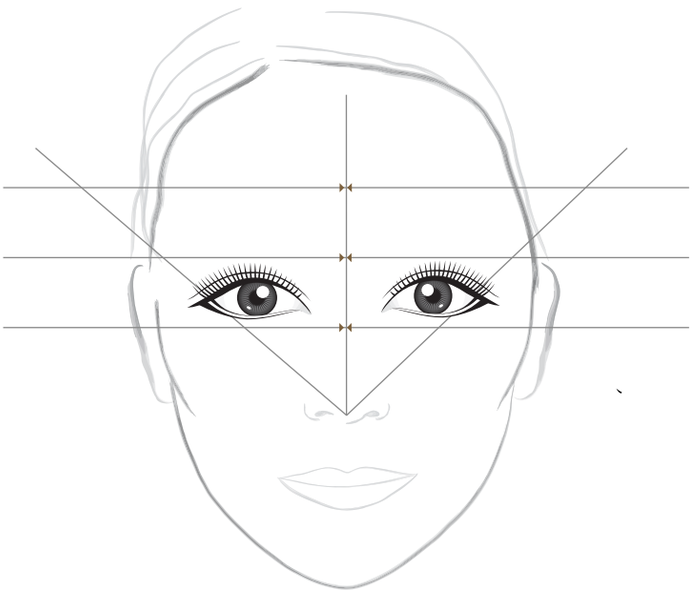
# PERMANENT MAKEUP

## CLIENT PERSONAL TRACKING FORM

File

Client Last Name Initial

Client Full Name



### TREATMENT DETAILS

- ◯ INITIAL PROCEDURE ◯ TOUCH-UP
- ◯ COVERUP / CORRECTION

**FITZPATRICK SKIN TYPE:** ◯ I ◯ II ◯ IV ◯ V

**SKIN TYPE:** ◯ NORMAL ◯ OILY ◯ COMBO ◯ DRY

**PORE SIZE:** ◯ SMALL ◯ MEDIUM ◯ LARGE

**BLEEDING:** ◯ – ◯ + ◯ ++ ◯ +++

**STYLE:** ☐ VIXEN ☐ MINIMALIST ☐ BOSS ☐ STUNNER ☐ REALIST

Treatment Notes & Description:

**THICKNESS:** ☐ 0.5 CM ☐ 0.6 CM ☐ 0.7 CM ☐ 0.8 CM ☐ 0.9 CM ☐ 1.0 CM

Touch Up Date: _____

**BOLDNESS:** ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Touch Up Notes:

**NEEDLE/BLADE:** _____

**NEEDLE LOT #:** _____

**NEEDLE MFD/EXP:** _____

**PIGMENT:** _____

**NOTES:**

Pricing

| Base Price | Touch Up Price | Other | **Total** |
|---|---|---|---|
| | | | |