Permanent Cosmetics Information and Consent Forms

Today's Date:____/____/____ Driver's License #:_____

Name:_____ Date of Birth: __/__/__ [F] [M]

Address:_____ Apt#:_____

City:_____ State:_____ Zip:_____

Home Phone (__)_____ Cell: (__)_____

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

May we call you at work? No Yes If yes, my work number is:(__)_____

Emergency Contact:_____ Phone:(__)_____ Relationship:_____

E-mail:_____

Ethnic Background, please include all nationalities: (this information will help us choose the correct pigment color for your skin type)_____

Who may we thank for referring you?_____

Procedure(s) Desired: ☐ Brows ☐Eyeliner ☐Lips ☐Camouflage ☐ Areola Complex ☐ Correction

Clinical Outcome of Procedure(s):

1. The results of your procedure is determined in part by the nature of the pathology of skin type, but not limited to the following factors:

- Medication you are currently taking.
- Skin characteristics: Dryness, oiliness, thickness, sun-damaged, color, chemically-damaged, etc.
- Natural skin undertones mixing with pigment color.
- Personal pH balance of skin, tanning booths, fruit acids, AHA's and Retin A use.
- Alcohol intake, smoking, sun exposure and improper skin care.
- Following Pre and Post instructions.
- In some cases, these factors can or may interfere with acceptance and overall fading of color pigment.

INFORMED CONSENT TO PROCEDURE

Initial:

1. I absolutely understand and accept that such procedure is a process, often requiring a follow-up application of color to achieve desirable results and that 100% success cannot be guaranteed. _____
2. Depending on the procedure(s), which I select, I accept responsibility for determining the color, shape, and position of eyebrows, eyeliners, lipliner and/or full lip color and the color of camouflage. _____
3. I understand the actual color of the pigment may be modified after the procedure, due to the tone and color of my skin. _____
4. I understand that positioning of my procedures can be affected if I elect to have cosmetic surgery, Botox or Restalyne. _____
5. 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. _____
6. If I am a lens wearer, I realize that I must keep my lenses out the day of an eyeliner procedure. _____
7. I understand that this procedure will fade and this fading can alter the original pigment color and that this determines that it is time for a touch-up. _____
8. I realize this is an elective tattoo process and therefore not an exact science, but an art, and is not medically necessary. _____
9. It has been explained to me that the following possibilities may occur: minor and temporary bleeding, swelling, infection, allergic reaction, hypertrophic scarring, keloid formation, cornea abrasion, bruising, redness or other discolorations, inconsistent color; and /or spreading or fanning of pigment. _____
10. I understand that laser procedures for hair removal or peri-oral lines may turn permanent lip color dark or even black as well as any Intense Pulse Lights (IPL's). _____
11. I give my consent to confer with my physicians for medical information required for the safety of my procedures. _____
12. I agree to accompany my technician to the emergency room in the event they were to be accidentally stuck with my needle and take a blood test for their safety and disclose all test results to my technician. _____
13. I am aware that if an infection occurs after I have received permanent cosmetics to see my primary physician and give us a call _____

Initial:

14. If I had permanent cosmetics performed previously by another technician, I will not hold _____ responsible for future allergic reactions or contraindications. _____

15. I understand that the taking of before and after photographs of the said procedure(s) are for the purpose of documentation, which may or may not be used for educational or advertising purposes. _____

16. I am over the age of 18, and not under the influence of any drug or alcohol. _____

ACCEPTANCE:

I have read and understand these risks listed above and they have been explained to me. **I DID NOT JUST SIGN THIS DOCUMENT.** I certify that the information in the above questionnaire is accurate and that it has been explained to me and my questions have been answered. I accept full responsibility for any complications that may arise or result during or following the cosmetic procedure(s) to be performed at my request.

Signature of Client:_____ Date:_____

Signature of Technician (s):_____Date:_____

_____

Medical Information	Yes	no
Have you ever had a fever blister, even one, in your life? Get regular canker sores?		
Are you pregnant or nursing		
Eyeliner only: Do you wear contact lenses?		
Do you have glaucoma or other eye disease or disorder?		
Have you ever had any eye trauma?		
Have you had a vision correction procedure such as RK or Lasik surgery in the last 3 months?		
Are you considering having vision correction procedures in the next 2 months?		
Are you prone to eye infections (i.e., conjunctivitis/pink eye)?		
Are you on a blood thinning medication?		
Do you take aspirin? Do you smoke? Drink alcohol?		
Are you on Accutane, or have you taken it within the last year?		
Do you have Mitral Valve Prolapse?		
Prior to dental procedures, do you receive antibiotic therapy?		
Are you on steroids or anti-inflammatory medications?		
Have you had an organ transplant?		
Are you an insulin diabetic?		
Do you have seizures or fainting spells?		
Do you bruise or bleed easily?		
Do you swell easily?		
Do you have a healing problem?		

	Yes	No
Camouflage only: Do your scars heal in a raised manner.		
Camouflage only: Do your scars heal in a darker color?		
Do you have keloids?		
Do you use Retin-A, Glycolic Acid, Vitamin C or other exfoliants?		
Do you have a dermatological disorder(s)? Disorder presently active or in a flare-up?		
Do you use a sunlamp or tanning bed?		
Are you currently tanned in the area(s) to be treated?		
Are you on Lithium?		
Do you have hemophilia or other clotting disorders?		
Do you have an autoimmune disorder?		
Have you ever had Hepatitis? Please circle: A B C When were you last tested?		
Do you have any pre-existing nerve damage in the area that I will be working on?		
Do you have any tattoos?		
Are any of the colors in your tattoo(s) sensitive to the sun or rise up in the sun?		
Do you have a hyperactive thyroid or Grave's disease?		
Do you have Alopecia Universalis (loss of hair)?		

Please check (✓) all that appply:

Have you ever had an allergic reaction to any of the following:

- Topical anti biotic ointments (i.e., Neosporin, Bacitracin, etc.)? _____ Novocain, Lidocaine, Epinephrine? _____ Cosmetics? _____ Seasonal (trees, pollen, hay fever)? _____ Latex rubber? _____ Metals, other?_____
- When at the dentist, do you anestitize easily? _____ Or does it take several Injections?_____
- Do you tint your brows?_____ Eyelashes?_____
- Have you had Gore-Tex implants in your lips?_____ Fat transfer to lips?_____ Any injectables in your lips (Restylin, collagen or other)?_Have you had a chemical peel?_____What type?_____When?_____
- Have you had Botox injections?_____ When?_____
- Do you spend a lot of time in the sun?_____ In chlorinated pool?_____
- Have you had any facial cosmetic surgery?_____ When?_____ Are you happy with the results?_____
- Are you planning facial cosmetic surgery in the near future?_____ When?_____
- Have you ever had laser treatments?_____ What type of lasers and why? _____

If you are presently under a physicians care for any condition, please describe:

Physician's Name:_____

Address:_____

Phone:_____

I hereby certify that, to the best of my knowledge, all statements contained hereon are true.

Client Signature:_____ Date:_____

Technician Signature (s):_____Date:_____