PERMANENT MAKEUP CONSULTATION FORM

GENERAL INFORMATION

Full Name _____ Date of Birth _____
Address _____
Contact Number _____ Email _____
What is your gender? ◯ Male ◯ Female ◯ Non-binary ◯ Other
Are you 18 years of age or over? ◯ Yes ◯ No
How did you hear about us? _____

PERSONAL HEALTH HISTORY

Is this the first time receiving permanent makeup? ◯ Yes ◯ No
If no, when/where was your last treatment _____
Please indicate any of the following treatments you have had in the past year:

◯ Skin grafts ◯ Laser resurfacing ◯ Alpha hydroxyl
◯ Hair removal procedures ◯ Chemical Peel ◯ RetinA
◯ Botox ◯ AHA/BHA ◯ Other

When was your last treatment? _____

Do you have a history of any of the following medical conditions:

◯ Alcoholism ◯ Epilepsy ◯ HIV Positive
◯ Alopecia ◯ Eczema ◯ Keloid Scarring
◯ Autoimmune Disorder ◯ Fainting Episodes ◯ Liver Disease
◯ Blisters/Herpes Simplex ◯ Fever ◯ MRSA
◯ Bleeding Disorders ◯ Forehead/Brow Lift ◯ Organ Transplant
◯ Cancer ◯ Face Lift ◯ Shingles
◯ Chemotherapy/Radiation ◯ Haemophilia ◯ Skin Conditions
◯ Diabetes ◯ Heart Condition ◯ Thyroid Issues
◯ Dermatitis ◯ Hepatitis (A,B,C,D) ◯ Tumours, Growths or Cysts
◯ Easy Bleeding ◯ High Blood Pressure ◯ Other

If other, please detail _____
When was your last treatment? _____

Have you had any allergic reactions to any of the following?

◯ Lidocaine (Anesthetic) ◯ Iron Oxide ◯ Eggs

PERMANENT MAKEUP CONSULTATION FORM

(continued)

When was your last treatment? _____

Have you had any allergic reactions to any of the following?

◯ Lidocaine (Anesthetic) ◯ Iron Oxide ◯ Eggs

Are you currently pregnant or nursing? ◯ Yes ◯ No

Do you have any allergies? ◯ Yes ◯ No
If 'Yes', please list here _____

Are you currently taking any medications including blood thinners? ◯ Yes ◯ No
If 'Yes', please list here _____

Do you use tanning beds or spend regular time in the sun? ◯ Yes ◯ No

Have you ever had any adverse reactions to any previous treatments? ◯ Yes ◯ No
If 'Yes', please state what kind of reaction you had

_____

Have you exfoliated or applied any products to your body in the last 24 hours? ◯ Yes ◯ No
If 'Yes', please state what products you used

_____

Please list your skin type:

◯ Dry ◯ Combination
◯ Oily ◯ Normal

Please list below any prescription or over the counter medication you are currently taking.

_____

_____

Certain conditions may affect how appropriate the treatment is. Please declare all relevant history as some conditions contraindicate the treatment.

PERMANENT MAKEUP
CLIENT CONSENT FORM

Permanent Makeup or Cosmetic Tattooing is a technique that applies permanent pigment into the dermis (skin) that allows a desired look to be achieved that resembles makeup. It can also be used to hide scars or help with an uneven hairline. This is preformed under a sterile environment

Permanent makeup uses iron oxides that pigments the skin. This pigmentation can last between 1-5 years. The pigment will gradually fade over time, however for most people it will not fade completely. 'Touch ups' of permanent makeup are advised usually after 3-6 months in order to achieve desired results.

With every treatment there are risks involved. It is important that you understand the risks prior to undergoing treatment. Ensuring you provide a full medical history can reduce these risks but even so there may be unforeseen risks that are presented. If you have any concerns regarding these risks, do not hesitate to contact your Healthcare Professional.

RISKS AND COMPLICATIONS

Possible risks and complications from the treatment:

- Temporary Pain
- Scarring
- Bleeding
- Peeling
- Scabbing
- Allergic Reaction
- Swelling
- Numbness
- Anaphalaxis
- Redness
- Infection
- Bruising
- Swelling

CONSENT

Please initial:

____ During the treatment, despite all the precautionary measures made by the Practitioner, injury is possible. I will not hold the Practitioner performing this service on me responsible in any issues that may arise because of having the procedure performed on me.

____ I understand that there are risks associated with Permanent Makeup, if any sort of reaction occurs I will seek medical attention and inform my Practitioner.

____ I understand that the color/outcome may not turn out as desired due to the undertone and health of my skin and that individual results will vary on each individual.

____ It is my responsibility to advise the Technician of any concerns I may have before the procedure.

____ I understand and agree to the aftercare instructions provided by my Technician. By not following the aftercare instructions I am aware that the desired results may not be achieved.

____ I understand the **permanence** of this procedure and my skin will be pigmented with iron oxides that may never fade completely.

I acknowledge and accept that no guarantees regarding the outcome of the procedure.

PERMANENT MAKEUP CONSENT FORM

(continued)

____ The Technician performing the procedure will not be held liable for and damages caused to me or my skin by any reason, including allergic reaction, skin sensitivity, and failure to follow the after care instructions.

____ I have declared all relevant history, and if any changes occur in the future I will notify my Technician.

____ I understand that this description of the procedure is not meant to scare or alarm me.

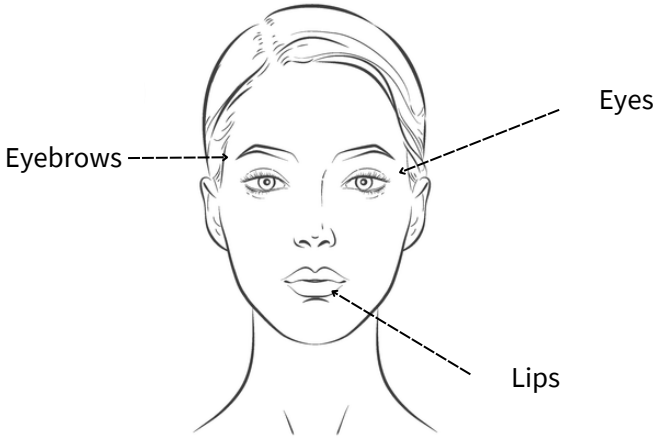
It is simply an effort to make me better informed so that I may give or withhold my consent for this procedure. I consent to the permanent makeup procedure being performed on me and accept that I understand the risks and complications involved.

_____	_____	_____
CLIENT NAME (PRINTED):	CLIENT NAME (SIGNATURE):	DATE:

PERMANENT MAKEUP

CLIENT TREATMENT PLAN

Client Name _____ Date _____ Time _____



Treatment/s carried out _____

Pigment colors used _____ Technique used _____

Brand _____ Blade/Needle(s) used _____ Pain level/Bleeding _____

Procedure notes _____

_____

_____

TECHNICIAN SIGNATURE:

Agreed Fee _____ Deposit Paid _____ Retouch Fee _____

RETOUCH TREATMENT

I can confirm there have been no change to my medical history since the last treatment.

_____ _____ _____

CLIENT NAME (PRINTED): CLIENT NAME (SIGNATURE): DATE:

Date _____ Time _____

Treatment/s carried out _____

Pigment colors used _____ Technique used _____

Brand _____ Blade/Needle(s) used _____ Pain level/Bleeding _____

Procedure notes _____

_____

_____

TECHNICIAN SIGNATURE:

PERMANENT MAKEUP

TREATMENT RECORD

GENERAL INFORMATION

Full Name _____ Date of Birth _____

Address _____

Phone _____ Email _____

TREATMENT	PRODUCTS USED	NOTES	PRICE	DATE

PERMANENT MAKEUP

PHOTO & VIDEO RELEASE FORM

I, _____ hereby give permission for any photos, videos, or audio that are taken of me to be used in and/or for any lawful promotional materials, such as but not limited to newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media pages, and other print and digital communications.

This authorization shall continue indefinitely and extends to all languages, media, formats and markets now known or later discovered.

I renounce all claims I may have to royalties or other forms of payment resulting from or connected to the use of the image or sound recording.

I understand and agree that these materials shall become the property of _____
and will not he returned.

All claims that I, my heirs, representatives, executors, administrators or any other person acting on my behalf or on behalf of my estate may hold them harmless and release them from any claims that they may bring.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement.

_____	_____	_____
CLIENT NAME (PRINTED):	CLIENT NAME (SIGNATURE):	DATE:

PERMANENT MAKEUP
CANCELATION POLICY

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment/cancelation policy.

Appointments are in high demand, and your early cancelation will give another person the opportunity to access to timely care. This policy allows us to better utilize available appointments for our clients.

At the time of booking your appointment you will be asked to pay a _____ deposit that will be credited towards your treatment/s.

Time had specifically been reserved for your appointment. If you need to cancel or reschedule your appointment you must call at least 24 hours prior to your appointment and your deposit will either be refunded or pushed for a future appointment. However, providing less than 24' hours notice will forfeit your deposit.

If you arrive more than 15 minutes for your appointment it is considered a no-show and your deposit will be forfeited.

We are happy to discuss any questions regarding this cancelation policy.

By signing below, I hereby acknowledge that I have completely read and fully understand the above Cancelation Policy. I agree to pay the cancelation fee in the event of a missed appointment.

_____	_____	_____
CLIENT NAME (PRINTED):	CLIENT NAME (SIGNATURE):	DATE:

Date _____ Time _____

PERMANENT MAKEUP

COVID-19 LIABILITY WAIVER & RELEASE FORM

Full Name _____ Date of Birth _____
Address _____
Contact Number _____ Email _____

Due to the COVID-19 Pandemic we require all clients to complete this form prior to having treatment to ensure the safety of the employees and clients.

I understand about the recent coronavirus. The World Health Organization has classified Covid-19 a global pandemic. I am aware that COVID-19 is very contagious and is spread through direct contact with people.

Please answer the following enquiries honestly and best as you can:
Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms?

- ◯ Fever
- ◯ Cough
- ◯ Chills
- ◯ Fatigue
- ◯ Head or muscle aches
- ◯ Shortness of breath
- ◯ Difficulty breathing
- ◯ Sore throat congestion or runny nose
- ◯ Loss of taste or smell
- ◯ Nausea, diarrea, vomit

Have you travelled internationally/domestically within the 14 days leading up to your appointment? ◯ Yes ◯ No

Have you visited/worked in any healthcare setting that have confirmed COVID-19 cases within the 14 days leading up to your appointment? ◯ Yes ◯ No

Have you recently been exposed to anyone with a confirmed case of COVID-19? ◯ Yes ◯ No

By signing below I confirm all the information above is correct, and I release the business from liability to any exposure to the coronavirus .

_____	_____	_____
CLIENT NAME (PRINTED):	CLIENT NAME (SIGNATURE):	DATE: