CONSENT TO PERMANENT MAKEUP & MICROBLADING

NAME _____ **DATE of BIRTH** _____

ADDRESS _____

CELL PHONE _____ **WORK PHONE** _____ **EMAIL** _____

SKIN TYPE: Review the Fitzpatrick Scale skin types below and check the one that best describes your skin. This information will help your technician determine the most appropriate way to approach your treatment(s):

- ☐ I. Very fair skin; blonde or red hair; light colored eyes; freckles common.
- ☐ II. Fair skinned; light hair, light eyes.
- ☐ III. Common skin type; fair; eye and hair color vary.
- ☐ IV. Mediterranean Caucasian skin; medium to heavy pigmentation.
- ☐ V. Mideastern skin; rarely sun sensitive.
- ☐ VI. Black skin; rarely sun sensitive.

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ☐ Yes ☐ No

TECHNICIAN: _____

PROCEDURE(s): _____

ESTIMATED COST: _____ **# OF VISITS REQUIRED:** _____

I declare that I am over the age of 18, not under the influence of drugs or alcohol, not pregnant or nursing, not on blood thinners or blood pressure medication, and am not an insulin-dependent Diabetic. I understand that many medications and some diseases and disorders may either contraindicate me for treatment or affect the results. I understand I should continue taking my medications, and tell my technician about all prescription and non-prescription drugs, supplements, topically applied products, eye drops, etc. that I use or take. I understand permanent makeup is a tattoo process; it is not an exact science, but an art. I have been informed of the general nature of permanent makeup and the specific nature of the procedure(s) described above.

Risks of Procedure(s): I understand there are risks associated with permanent makeup, including, but not limited to: Infection: Procedures which involve penetrating the skin could cause infection; Scarring: Recovery from the procedure(s) could lead to scarring; Allergic reaction: Pigments, dyes, or other materials used could cause a reaction; Color: Colors will vary based on skin tone, pigments may fade over time; Irregularity: Pigments may fan or spread, causing makeup lines to blur; Corneal Abrasion: Rubbing or scratching eyes or applying contacts shortly after an eyeliner procedure could cause an abrasion; Permanence: Permanent makeup is intended to produce long-lasting changes to appearance which may be difficult or impossible to modify or remove.

Pigment Allergy Patch Test: ***I Consent*** to a Patch Test:_____ ***I Waive*** the Patch Test:_____

(While an allergy patch test is recommended, it does not always accurately predict whether you will have a reaction. If waived, you release the technician from liability if you then have an allergic reaction to the pigment.)

Other Treatment: I understand that if I have any skin treatments, including, but not limited to laser hair removal, plastic surgery or other skin altering procedures, it may result in adverse changes to my permanent cosmetics. I acknowledge some of these potential adverse changes may not be correctable. **X**_____

Pre-Procedure and Aftercare Instructions: I have received, and will strictly adhere to, all pre-procedure and aftercare instructions. I understand that my failure to do so may jeopardize my chances for a successful procedure. If I am on any medication for depression or any other mood altering prescription, I will advise my technician. If I have ever had cold sores, I will consult with and strictly follow my doctor's instructions before contemplating any permanent cosmetic procedure around my lips. **X**_____

I certify that this consent has been fully explained to me, that I have read and initialed the above paragraphs, and that I elect to receive the permanent makeup procedure(s) indicated above. I understand the permanence of the procedure(s) as well as the possible complications and consequences of the procedure(s). I consent to my photograph being taken before and after the procedure(s).

CLIENT SIGNATURE: _____ **DATE:** _____

TECHNICIAN SIGNATURE: _____ **DATE:** _____

Client Health History: Permanent Makeup and Microblading Health History Intake

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ Work: _____

Email: _____ Preferred Contact: Cell____ Work ____ Email _____

Emergency contact name: _____ Phone _____

Relationship to you: _____

Are you over the age of 18 years? Yes___ No___

SKIN TYPE: Review the skin types below, using the Fitzpatrick Scale, and check the one that best describes your skin. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):

- ❑ I. Very fair skin; blonde or red hair; light-colored eyes; freckles common
- ❑ II. Fair skinned; light hair, light eyes
- ❑ III. Very common skin type; fair; eye and hair color vary
- ❑ IV. Mediterranean Caucasian skin; medium to heavy pigmentation
- ❑ V. Mideastern skin; rarely sun sensitive
- ❑ VI. Black skin; rarely sun sensitive

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ❑ Yes ❑ No

Please list the products you use regularly:

Facial Cleanser _____ Moisturizer _____

Toner _____ Serum _____

Scrubs _____ Sunscreen _____

Retinol _____ Glycolic Acid _____

Enzymes _____ Peptides or Growth Factors _____

Cosmetic History

How would you describe your skin? ___Normal ___Combination ___Oily ___Dry

Have you had microblading or permanent makeup in the past? Yes___ No___

If yes, what area(s) were treated? _____

Do you have any scars in or around the area to be treated? Yes____ No___

Are you prone to keloid or hypertrophic scarring? Yes____ No_____

Have you ever had any of the following injectables or implants?

Botox	Radiesse	Perlane	Collagen	Dysport
Juvederm	Restylane	Silicone	Sculptra	

Other: _____

Continued ⇨

Client Health History: Permanent Makeup and Microblading Health History Intake

If yes, when? _____ What body area(s)? _____

Have you had any other cosmetic surgeries/procedures? Yes ___ No___ If yes, when? _____

What body area(s)? _____

Have you used Accutane in the past year? Yes____ No____

Health History

Have you had chemotherapy in the past 6 months? Yes___ No_____

Do you have any of the following conditions:

___Alopecia ___Trichotillomania (compulsive pulling of body hair) ___Eczema ___Dermatitis

___Pregnancy and/or breastfeeding ___Autoimmune disease ___Herpes Simplex ___Diabetes

___History of stroke ___Heart disease and/or heart defects ___Hemophilia ___High blood pressure

Do you have any other health conditions not mentioned here? Yes___ No___ If yes, please list _____

_____

Do you have moles/skin growths in the area to be treated? Yes___ No___

Do you or have you had a piercing in the area to be treated? Yes____ No___

Have you ever had a reaction at the dentist or any other time from numbing? Yes___ No___

Do you have any allergies to medications, food, latex, topical products, and/or other substances?

Please list: _____

Have you consumed drugs or alcohol in the last 24 hours? Yes___ No___

Have you undergone surgery in the last 2 weeks? Yes___ No___

Please list all vitamins and supplements including herbal remedies you take regularly _____

_____

Please list all current medications including aspirin, ibuprofen, blood thinners, etc. you take regularly _____

_____

What are you hoping to accomplish through microblading? _____

_____

Is there anything else you would like us to know? _____

_____

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

Client Name (Printed) _____

Client Name (Signature) _____ Date: _____

Esthetician/Technician: _____ Date: _____

Client Information and Consent—Waxing

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email address: _____

Have you used any Alpha Hydroxy Acid (AHA) or glycolic products in the past 48-72 hours? ❍ No ❍ Yes

Are you using Retin-a, Renova or Accutane (an oral form of Retin-a)? ❍ No ❍ Yes

Are you using any other skin thinning products and/or drugs? ❍ No ❍ Yes

Are you exposed to the sun on a daily basis or are you considering spending more time in the sun soon? ❍ No ❍ Yes

Do you use a tanning bed? ❍ No ❍ Yes

Are you diabetic? ❍ No ❍ Yes

Are you currently taking medications? If so, please list all (including over the counter drugs/herbal supplements):

_____

_____

What skin products do you regularly use on your skin?

_____

_____

Have you ever been treated for cancer? If yes, when and what types of therapies were used?

_____

_____

Please list any other illness/condition you are currently being treated for by a medical professional

_____

_____

(Female clients) When is your next menstrual cycle due to begin?_____

(Always allow five days for menstrual cycle. Because of water retention and for your own personal comfort, you should avoid hair removal two days before your cycle is due and two days after it is completed.)

Please note that waxing does have certain side effects such as skin removal, redness, swelling, tenderness, etc.
I have read the above information and if I have any concerns, I will address these with my skin therapist. I give permission to my therapist to perform the waxing procedure we have discussed and will hold her and her staff harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as possible.

I have read and understand the post-treatment home care instructions. I am willing to follow recommendations made by my esthetician for a home care regimen that can minimize or eliminate possible negative reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home product / post-treatment care, I will consult the esthetician immediately.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (printed) _____

Client Name (signature) _____ Date_____

Esthetician _____ Date_____