



Summit Ink & Beauty
3 Brussels St Suite 308
Worcester Ma 01610
508-736-3335

Informed Client Consent

Today's Date: ___/___/20__

Client Info:

Name: _____ Date of Birth: ___/___/___ Email: _____

Ethnic Background *(Please include all nationalities)*: _____

Address: _____ Apt. #: _____ Home Phone: (____) ____ - ____

City: _____ State: _____ Zip Code: _____ Cell Phone: (____) ____ - ____

Occupation: _____

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

May we call you at work? Yes No If yes, my work number is (____) ____ - ____

Emergency Contact Information:

Name: _____ Phone: (____) ____ - ____ Relationship: _____

Who may we thank for referring you? _____

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

List all medications you are presently taking

Name of Drug	mg or mcg	Amount/Day	Why it was prescribed to you?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all medications you took in the last six months that you are no longer taking

Name of Drug	mg or mcg	Amount/Day	Why it was prescribed to you?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

GENERAL MEDICAL

Client Name: _____

DO YOU HAVE (CHECK ALL THAT APPLY)

- Fever Blisters/Cold Sores (Ever, even one time)
- Glaucoma or other eye disease/disorder
- Grave's Disease
- Heart Disease
- Shingles History/Recent Shingles Shot
- Mitral Valve Prolapse
- Valve Implants
- Pacemaker
- Stents
- Diabetes requiring insulin
- Problems with healing
- Keloids
- Seizures
- Dermatological Disorder
 - If so, what? _____
 - Active or in Flare-ups? _____
- Hemophilia or Clotting Disorder
- Autoimmune Disorder
- Pre-existing nerve damage
- Tattoos: Colors you are sun sensitive to:
 - _____
- Trichotillomania (pulling of hair, brows, lashes)
- Alopecia Totalis or Areata
- Allergies
 - List: _____

DO YOU USE (CHECK ALL THAT APPLY)

- Accutane (currently or within the past year)
- Antibiotics prior to dental procedures
- Steroids
- Retin-A, Glycolic Acid, Vitamin C or other Exfoliants
- Tanning Beds
- Eyebrow Tinting
- Eyelash Tinting
- Latisse
- Botox *When?* _____
- Chemical Peels *When?* _____
- Chemotherapy or Prophylactic dose of Chemotherapy
- Blood Thinners

HAVE YOU HAD (CHECK ALL THAT APPLY)

- Fever Blisters/Cold Sores (Ever, even one time)
- Eye Infections (Are you prone to them)
- Vision Correction Procedure (Lasik, RK) within the past 3 months
- Heart Attack *When?* _____
- Joint Replacement, Organ Transplant
- Eye Trauma
- Seizures
- Fainting Spells
- Hepatitis *What type?* _____
- Hepatitis Test *When?* _____
- Fat Transfer Injections
 - If yes, where? _____
- Gore-Tex Implants
 - If yes, where? _____
- Aesthetic or Cosmetic Procedures
 - If yes, where? _____
- Laser Treatments
 - What type & why? _____

ARE YOU? (CHECK ALL THAT APPLY)

- Pregnant
- Planning cosmetic surgery
 - If so, what & when? _____
- Currently under the care of a physician
 - Describe: _____

DO YOU PRACTICE OUTDOOR ACTIVITIES? (CIRCLE ALL THAT APPLY)

- | | |
|-----------|--------------|
| Tennis | Swimming |
| Golf | Skiing |
| Gardening | Walking |
| Boating | Other: _____ |

Physician's Name: _____
 Address: _____
 Phone: (____) ____ - ____ Specialty: _____

Signature of Practitioner: _____
 Date: ___/___/20___

INFORMED CONSENT TO PROCEDURE

(PLEASE READ ALL QUESTIONS THOROUGHLY BEFORE SIGNING)

Initial

1. Are you pregnant or nursing? Yes No _____
2. I absolutely understand and accept that such procedure is a process, often requiring multiple applications of color to achieve desirable results and the 100% success cannot be guaranteed. _____
3. I have received, reviewed and understand the pre-procedural and post-procedural instructions given to me and agree to follow them. _____ as
4. Depending on the procedure(s), which I select, I accept responsibility for determining the shape, and position of eyebrows, eyeliners, lipliner and/or full lip color. _____
5. I understand that the color selection and color results in all procedures are not an exact science. _____
6. I understand that positioning of my procedures can be affected if I have elected or wish to elect cosmetic surgery, Botox, or Restalyne, and I assume this responsibility. _____
7. 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. _____
8. If I am a lens wearer, I realize that I must keep my lenses out the day of an **eyeliner procedure**. _____
9. I understand that this procedure will fade and this fading can alter the original pigment color and that this determines that it is a time for a touch-up visit. _____
10. I realize this is an elective cosmetic procedure and is not medically necessary. _____
11. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment. _____
12. I understand that many lasers & IPL's (Intense Pulse Lights) including those used for hair removal, anti-aging, Photo Facials, removal of lines may or will turn permanent make up dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent make up. _____
13. I give my consent to **INSERT BUSINESS NAME** to confer with my physicians for medical information required for the safety of my procedures. _____
14. I agree to accompany my practitioner to the emergency room in the event they were to be accidentally stuck with my needle and take a blood test for their safety & disclose all test results to my practitioner. _____
15. I am aware that if an infection occurs after I have received Permanent Cosmetics to see with my primary physician or an emergency room **immediately**. _____

ACCEPTANCE:

I have read and understand these risks listed above and they have been explained to me. I certify that the information in the above questionnaire is accurate and my questions have been answered.

Signature of Client: _____

Date Signed: ___/___/20___

Signature of Practitioner: _____

Date Signed: ___/___/20___

PHOTOGRAPH AND PUBLICITY RELEASE FORM

I, _____, give my permission to use my likeness, image, and/or appearance as such may be embodied in any pictures, photos, video recordings, digital images, and the like, taken or made on behalf of **Insert Business Name**. I agree that **Insert Business Name** has complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with the **Insert Business Name** mission. These uses include, but are not limited to illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials in any medium now known or later developed, including the Internet. I acknowledge that I will not receive any compensation, etc. for the use of such pictures, etc., and hereby release **Insert Business Name** and its agents and assigns from any and all claims which arise out of or are in any way connected with such use.

I have read and understood this consent and release.

I give my consent to **Insert Business** to use my likeness to promote the company, and/or their activities.

Signature

Date

Print Name