Pretty Please Permanent Makeup

11 East Main Street
Marlton, NJ 08053

Today's Date: ___/___/20___

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 <u>in the last six months</u> that you are no longer taking

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

Practitioner Signature: _____ **Date:** ___/___/20 ___
Client Signature: _____ **Date: __/___/20___**

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

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
Golf
Swimming
Skiing

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?

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

Client :_____Date:__/__/ 20__
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 touchups to achieve desirable results and the 100% success cannot be guaranteed. _____
3. I am aware that touch ups are charged separately from the initial procedure. _____
4. I have received, reviewed and understand the pre-procedural and post-procedural instructions as given to me and agree to follow them. _____
5. 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. _____
6. I understand that the color selection and color results in all procedures are not an exact science. _____
7. 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. _____
8. 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. _____
9. If I am a lens wearer, I realize that I must keep my lenses out the day of an **eyeliner procedure**. _____
10. 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. _____
11. I realize this is an elective cosmetic procedure and is not medically necessary. _____
12. 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. _____
13. 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. _____
14. I give my consent for Pretty Please Permanent Makeup LLC to confer with my physicians for medical information required for the safety of my procedures. _____
15. 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. _____
16. I am aware & agree that if an infection occurs after I have received Permanent Cosmetics to seek guidance by 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 **Pretty Please Permanent Makeup LLC**. I agree that **Pretty Please Permanent Makeup LLC** has complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with the **Pretty Please Permanent Makeup LLC** 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 **Pretty Please Permanent Makeup LLC** 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 **Pretty Please Permanent Makeup LLC** to use my likeness to promote the company, and/or their activities.

_____ _____

Signature Date

_____

Print Name

Client Name: _____ **Date:** ___/___/20___

Procedure Type:

Tool/Product	Brand	Lot Number	Expiration
Needle(s)			
Topical Anesthetic(s)			
Pigment(s)			
Other Product(s)			

PROCEDURE NOTES:

_____

_____

_____

_____

_____

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