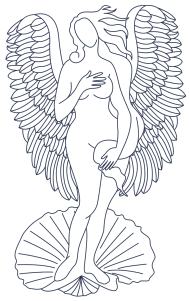
PERMANENT MAKEUP
CLIENT INFORMATION FORM



Appointment date / time:

FULL NAME :

DOB :

CURRENT AGE :

Proof of ID required
- State issued photo ID or US Military Card

ADDRESS :

OCCUPATION :

GENDER :

PHONE :

EMAIL :

EMERGENCY CONTACT

NAME :

PHONE :

RELATIONSHIP :

PLEASE SELECT THE PROCEDURE SCHEDULED AT INITIAL APPOINTMENT.

◯ **Permanent Eyebrows**- Symmetry, thickness, and pigment shade is determined in a thorough skin analysis and one on one skin mapping session.

◯ **Watercolor Lip Blush**- It gives the illusion of volume by carefully mapping your lip's natural shape.

◯ **Ultra Realistic 2D Areola Tattoo (Unilateral)**- This advanced paramedical tattoo procedure utilizes the nipple like structure placed by your surgeon restoring color and dimension to the breast.

◯ **Ultra Realistic 3D Areola Tattoo (Unilateral)**- This advanced paramedical tattoo procedure utilizes the blank canvas left by your surgeon restoring color, nipple, and dimension to the breast.

CLIENT INFORMATION
CONTINUED

HAVE YOU HAD PERMANENT MAKEUP IN THE PAST?

◯ Yes When? _____ ◯ No

PLEASE TICK IF YOU ARE USING ANY OF THE FOLLOWING:

◯ Retin A

◯ Chemical Peels

◯ Gastroint Vitamin C Facial Serumestinal

◯ Musculoskeletal

◯ Laser Treatments (eg. IPL, etc.)

◯ Glycolic Acid or ANY Exfoliating Products or Enzymes

◯ NONE

◯ Other:_____
_____
_____
_____

ARE YOU PLANNING TO UNDERGO ANY COSMETIC SURGERY?

◯ Yes When? _____ ◯ No

HAVE YOU UNDERGONE TATTOO REMOVAL FOR ANY PREVIOUS PERMANENT MAKEUP?

◯ Yes ◯ No

_____ _____

Client's Name Client's Signature

_____ _____

Date / Month / Year Cosmetic Professional's Signature

CLIENT MEDICAL HISTORY

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL PROBLEMS?

- ◯ No
- ◯ Yes Please specify reason/s:

_____

_____

PRIMARY PHYSICIAN'S INFORMATION

FULL NAME :

ADDRESS :

CONTACT :

DO YOU TAKE ANTIBIOTICS PRIOR TO A DENTAL PROCEDURE?

◯ Yes ◯ No

ARE YOU CURRENTLY...

- ◯ Pregnant or Nursing
- ◯ Undergoing Chemotherapy and/or Radiation Treatments (Prophylactic Chemotherapy is generally safe to proceed)
- ◯ Undergoing active dermatologic disorders to the area being treated (eg. rosacea, eczema, & psoriasis)
- ◯ NONE

DO YOU HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING? (TICK ALL THAT APPLIES)

- ◯ NONE
- ◯ Autoimmune Disorder
- ◯ Problems with Healing
- ◯ Keloids
- ◯ Pre-existing Nerve Damage
- ◯ Alopecia Totalis or Areata
- ◯ Trichotillomania (Pulling of hair, brows, or lashes)
- ◯ Prone to Eye Infections
- ◯ Fainting Spells
- ◯ Eye Trauma
- ◯ Mitral Valve Prolapse

CLIENT MEDICAL HISTORY
CONTINUED

DO YOU HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING? THE FOLLOWING REQUIRES MEDICAL CLEARANCE FROM YOUR DOCTOR AND PREMEDICATION.

- ◯ NONE
- ◯ Joint Replacement
- ◯ Skin Disease or Skin Lesions
- ◯ Seizures, Epilepsy, Fainting or Narcolepsy
- ◯ Pre-existing Nerve Damage
- ◯ Fever Blister History (Note: Required for LIP BLUSH only)
- ◯ HIV
- ◯ Organ Transplant
- ◯ Insulin Dependent Diabetes
- ◯ Heart Valves, Stents, Pacemakers, Rheumatic Fever
- ◯ Hemophilia or any Blood Clotting Disorder
- ◯ Allergies or adverse reactions to pigments, dyes, or other skin sensitivities
- ◯ Suspicion of adverse reaction to LATEX or products containing latex

HAVE YOU HAD LASIK OR CATARACT SURGERY WITHIN THE PAST 3 MONTHS? IF YES, WE REQUIRE MEDICAL CLEARANCE FROM YOUR DOCTOR.

◯ Yes ◯ No

ARE YOU CURRENTLY TAKING BLOOD THINNERS?

EX: aspirin or other anticoagulants (such as warfarin, Xarelto™, Plavix, Eliquis™, etc.

◯ Yes ◯ No

HAVE YOU HAD BOTOX OR DISPORT WITHIN THE PAST 24 HOURS?

◯ Yes ◯ No

HAVE YOU HAD LIP FILLERS WITHIN THE PAST 2 WEEKS PRIOR TO YOUR APPOINTMENT? FOR LIP BLUSH ONLY.

◯ Yes ◯ No

HAVE YOU HAD FAT TRANSFER IN THE LIPS WITHIN THE PAST MONTH? FOR LIP BLUSH ONLY.

◯ Yes ◯ No

HAVE YOU HAD ACCUTANE WITHIN THE PAST YEAR?

◯ Yes ◯ No

HAVE YOU HAD HEPATITUS?

◯ Yes Type? _____When?_____

◯ No

HAVE YOU USED A TANNING BED IN THE PAST 4 WEEKS?

◯ Yes ◯ No

CLIENT MEDICAL HISTORY
CONTINUED

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

LIST ALL MEDICATIONS YOU TOOK IN THE LAST SIX MONTHS THAT YOU ARE NO LONGER TAKING

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please note in SOME INSTANCES, a medical clearance may be required in order to safely provide tattoo services. Clients that need to secure medical clearance should submit their medical clearance 24 hours before their scheduled appointment to avoid cancellation.

_____ _____
Client's Name Client's Signature

_____ _____
Date / Month / Year Cosmetic Professional's Signature

INFORMED CONSENT

Please verify by initialing each statement that you have read, understand, and agree to the following:

_____ **I HAVE READ, UNDERSTAND, AND AGREE TO THE PRE-APPOINTMENT INSTRUCTIONS AS GIVEN TO ME THROUGH VERBAL AND/OR AS POSTED ON THE WEBSITE.**

_____ **I UNDERSTAND AND ACCEPT THAT THE PROCEDURE IS A PROCESS AND OFTEN REQUIRE MULTIPLE APPLICATIONS.**

_____ **I ACCEPT THE RESPONSIBILITY FOR DETERMINING THE SHAPE, AND POSITION OF THE EYEBROWS, LIPS, AREOLA, OR MEDICAL ART FOR THE PROCEDURE/S I HAVE SELECTED.**

_____ **I UNDERSTAND THAT THE COLOR SELECTION AND COLOR RESULTS IN ALL PROCEDURES ARE NOT AN EXACT SCIENCE.**

_____ **I UNDERSTAND THAT THE POSITIONING OF MY PROCEDURE/S CAN BE AFFECTED IF I HAVE ELECTED OR WISH TO ELECT COSMETIC SURGERY, BOTOX OR RESTALYNE, AND I ASSUME FULL RESPONSIBILITY.**

_____ **I AM AWARE THAT IF I AM TO UNDERGO MRI AFTER THE PROCEDURE, I MUST TELL THE RADIOLOGIST THAT I HAVE IRON OXIDE PERMANENT COSMETICS.**

_____ **I UNDERSTAND THAT THIS PROCEDURE WILL FADE AND IT CAN ALTER THE ORIGINAL PIGMENT COLOR AND THAT THIS DETERMINES THAT IT IS A TIME FOR A TOUCH-UP VISIT.**

_____ **I UNDERSTAND THIS IS AN ELECTIVE COSMETIC PROCEDURE AND IS NOT MEDICALLY NECESSARY.**

_____ **I UNDERSTAND THAT THE FOLLOWING POSSIBILITIES MAY OCCUR: -MINOR AND TEMPORARY PIN POINT BLEEDING;-POSSIBLE BRUISING;-REDNESS OR OTHER DISCOLORATION;-SWELLING;-FEVER BLISTERS ON THE LIP AREA FOLLOWING LIP PROCEDURES; AND/OR-FADING AND LOSS OF PIGMENT**

INFORMED CONSENT
CONTINUED

_____ **I UNDERSTAND THAT MANY LASERS & IPL'S (INTENSE PULSE LIGHTS) INCLUDING THOSE USED WITH PHOTO FACIALS, REMOVAL OF LINES MAY TURN PERMANENT MAKEUP DARK OR EVEN BLACK. I AGREE TO INFORM MY ESTHETICIAN OR ANYONE OPERATING SUCH THAT I HAVE PERMANENT MAKE UP.**

_____ **I GIVE MY CONSENT TO SIREN'S INK COSMETIC TATTOOS & ADVANCED MEDICAL ART TO CONFER WITH MY PHYSICIAN/S FOR MEDICAL INFORMATION REQUIRED FOR THE SAFETY OF MY PROCEDURES.**

_____ **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.**

_____ **IF AN INFECTION OCCURS AFTER I HAVE RECEIVED PERMANENT COSMETICS, I AGREE TO CONTACT MY PRIMARY PHYSICIAN OR AN EMERGENCY ROOM IMMEDIATELY.**

_____ **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.**

_____ **I HAVE READ, UNDERSTAND, CONSENT AND AGREE TO ALL AFTERCARE INFORMATION LISTED ON WWW.SIRENSINK.COM/AFTER-YOUR-VISIT/**

_____ **I HAVE READ, UNDERSTAND, CONSENT AND AGREE TO ALL POLICIES LISTED ON WWW.SIRENSINK.COM/POLICIES/**

_____	_____
Client's Name	Client's Signature
_____	_____
Date / Month / Year	Cosmetic Professional's Signature

DISCLAIMER OF LIABILITY

I understand and acknowledge that:

1. A tattoo is a kind of body art where a dye is punctured into the dermis layer of the skin to make artistic designs. This is done either for cultural practices, expressionism, or simply for aesthetic purposes to one's body.
2. A tattoo is a permanent change to the appearance of the skin and it may be difficult to modify or remove the tattoo should I decide so later on.
3. I do not have a medical or skin condition that may interfere or cause undesirable results to my skin in the tattoo area.
4. It is my responsibility to inform the tattoo artist of any condition that I may have such as irritations, scarring, eczema, moles, or any that may interfere with said tattoo.
5. I am not under the influence of alcohol and drugs.
6. Infection is possible after obtaining a tattoo. I shall ensure that I comply with the recommended standard of care to have better healing of my skin. In this regard, I have received aftercare instructions from the tattoo artist and agree to abide by such instructions.
7. There might be instances of touch-up work needed. In such cases, should it be my fault, I shall be responsible for any additional cost for such work.
8. It is not the responsibility of the tattoo artist to do clinical tests on my skin whether my skin is sensitive to materials used for tattooing. In such instances, I accept the risks of such allergic reactions.
9. Colors may vary from presented catalogs or images and such color results may depend on the color of my skin as well.
10. Any skin treatment over the tattoo area may have adverse effects on my tattoo such as laser treatments, chemical treatments, among others.

By signing and submitting this form, I acknowledge that I have been given the opportunity to ask questions with regard to the risks of obtaining a tattoo which have been answered to me to my satisfaction. I acknowledge I am at least eighteen (18) years of age and I have no mental condition. I likewise have no physical condition that might affect my well-being as a result in having a tattoo on my skin. I give my full consent to the application for obtaining a tattoo without influence, coercion, or representation from any person.

_____	_____
Client's Name	Client's Signature
_____	_____
Date / Month / Year	Cosmetic Professional's Signature

PHOTO & VIDEO CONSENT

FOR THE PURPOSE OF DOCUMENTATION, I CONSENT TO THE TAKING OF BEFORE AND AFTER PHOTOGRAPHS AND VIDEOS. YOUR ARTIST REQUIRES YOU TO CONSENT TO PHOTOGRAPHS FOR HER PROFESSIONAL AND CONFIDENTIAL CUSTOMER FILES.

I CONSENT TO THE USE OF MY PHOTOS FOR THE PURPOSE OF MARKETING. MY PICTURES MAY APPEAR IN OR ONLINE.

Client's Name

Client's Signature

Date / Month / Year

Cosmetic Professional's Signature

FOR ANY COMPLAINTS OR CONCERNS YOU MAY CONTACT:

Fayette County Environmental Health
140 Stonewall Ave W, Suite 200, Fayetteville, GA 30214
770-305-5415