Registration and History Form

Today's Date ________/_____/________

Name ______________________________________ Date of Birth ______/_____/______ Email: ____________________________

Ethnic Background, please include all nationalities ____SS#____________________

Address ____Apt. # ____________City:_________________________________

State _________ Zip ______________ Home Phone (_____)_________________ Cell (____)______________________________

Occupation: _____________________________ If we call you at home, do you want confidentiality? ☐ No ☐ Yes

May we call you at work? ☐ No ☐ Yes If Yes, my work number is (______)______________________

Emergency Contact, 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.	How many ea. 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.	How many ea. day	Why it was prescribed to you

GENERAL MEDICAL

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

______ Mitral Valve Prolapse/Valve Implants/Stents/rheumatic Fever

______ Pacemaker

______ High Blood Pressure-uncontrolled

______ HIV/AIDS

______ Diabetes requiring insulin

______ Problems with healing

______ Keloids (Scarring)

______ 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

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 Boating
Gardening Walking Other:____________________

Physician's Name:_________________________________
Address: ____
Phone: ____
Specialty: ____

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)**
If yes, you must contact your physician for a prescription of ZOVIRAX capsules, an antibiotic that prevents cold sore. I have read the above information regarding ZOVIRAX and understand it's mandatory if I desire Lip Liner or Full Lip Procedure. ______________

______ 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? ___________________________
____

Client Name ______________________________________
Signature of Practitioner Date / /

INFORMED CONSENT TO PROCEDURE

Client Name:______________________

Initial:

1 I, ___________________________________ am over the age of 18, am not under the influence of drugs or alcohol and desire to receive the indicated permanent cosmetic procedure. The general nature of permanent cosmetics and as well as the specific procedure to be performed has been explained to me. __________

2. I understand scar relaxation and scar camouflage work is complicated and can be more complex than standard micropigmentation and that several appointments may be required to achieve a good final result. I also understand that this is not an exact science and that there can be complications in Scar relaxation and Scar camouflage to include but not limited to additional scarring and irregular blending of the pigments to match the natural skin tones and do not hold Tint and/or JoAnne Christman responsible and/or liable. _________

3. I have been informed of the nature, risks, and possible complications and consequences of permanent skin pigmentation. I understand the permanent skin pigmentation procedure carries with it know and unknown complications and consequences associated with this type of cosmetic procedure, including but not limited to: infection, allergic reaction, scarring, inconsistent color, and spreading, fanning or fading of pigments. I understand the actual color of the pigment may be modified slightly, due to the tone and color of my skin. I fully understand that permanent cosmetics is not an exact science. I request the permanent skin pigmentation procedure(s), and accept the permanence of the procedure as well as the possible complications and consequences of the said procedure(s). __________

4. 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. __________

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 to Tint and/or JoAnne Christman 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 that if an infection occurs after I have received Permanent Cosmetics to see with my primary care physician or an emergency room, ***immediately***. I am also aware that after seeking medical help that I will contact Tint and/or JoAnne Christman to make known of the circumstances involving medical treatment. __________

17. I understand that if I am on any medication for depression or any other mood altering prescription, I will advise my technician. __________

18. I understand that 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. _________

19. I understand that micropigmentation shall not be performed if you have a history of jaundice, hepatitis, HIV or other similar disease, and you shall in writing document this information relating to such diseases on your medical history form completed by you as the client. __________

20. If I had permanent cosmetics performed previously by another practitioner, I do not hold TINT and/or JoAnne Christman responsible for future allergic reactions or contraindications. __________

21. I am aware that if I am pregnant or nursing that a permanent cosmetics procedure can not be performed and will have to be rescheduled. Are you Pregnant? YES NO

22. I understand that the taking of before and after photographs of the said procedure(s) are a condition of such procedure(s). I certify I have read and initialed the above paragraphs and have had explained to my understanding this consent and procedure permit. I accept full responsibility for the decision to have this permanent cosmetic procedure performed on myself. __________

23. **Scratch test:**
I am aware that a pre-procedure scratch test performed on me by Tint and/or JoAnne Christman is to test for the possibility of an immediate allergic reaction to the pigments and/or topical anesthetic's used and that this test does not rule out the possibility of any future allergic reaction to the pigments and/or anesthetic's that may occur after the permanent cosmetic procedure has been performed. I also understand that I have the choice to not have the scratch test if I so desire.

I would like to have the scratch test performed prior to my permanent cosmetics procedure to test for an immediate allergy reaction. Yes No __________

ACCEPTANCE:

I have read and understand these risks listed above and they have been explained to me. **I DID NOT JUST SIGN THIS DOCUMENT.** I certify that the information in the above questionnaire is accurate and my questions have been answered. I accept full responsibility for any complications that may arise or result during or following the cosmetic procedure(s) to be performed at my request.

Signature of Client X____

Signature of Practitioner ____ **Date** _____/____/__ ______