Aesthetica Medical Spa
Permanent Cosmetics
Client Information Sheet

Name_____Date of Birth:_____

Address_____City_____State_____Zip_____

PHONE (Day)_____ Night_____

May we contact you at these numbers if necessary? ☐Yes ☐No

Procedure(s) Desired:

☐Eyeliner ☐Eyebrows ☐Lipline ☐Full Lip Color ☐Nipples

☐Beauty Mark ☐Skin Repigmentation ☐Other_____

If you selected "other" please explain:_____

Have you **ever** had a herpes or cold sore? ☐Yes ☐No If yes, contact your physician for a prescription of ZOVIRAX or some other anti-viral medication.

I have read the above information regarding an anti-viral and understand its use is mandatory if I desire lipliner or full lip color procedures.

*Signed:_____ (Client)

Who referred you:_____

Are you currently under the care of a physician? ☐Yes ☐No

If so, why?_____

_____

Physician's name:_____

Do you take antibiotics when going to the dentist? ☐Yes ☐No If Yes, Why?_____

Do you suffer from: ☐Allergies ☐Moles or freckles at site of tattoo ☐Hepatitis

☐Heart Problems ☐Hemophilia ☐Diabetes ☐Skin Problems ☐Scarring (Keloids)

☐Eye Problems ☐Epilepsy ☐Other: Please explain:_____

Are you presently taking any medication which thins the blood? ☐Yes ☐No

Are you taking other medications including anti-depression or mood altering drugs? ☐Yes ☐No If yes, explain:_____

Are you pregnant or nursing? ☐Yes ☐No

Do you wear contact lenses? ☐Yes ☐No If yes, bring glasses to your eyeliner appointment as you cannot put in contact lenses directly after a procedure.

The above is complete and accurate as to my medical history.

*Signed:_____(Client) Date:_____

Aesthetica Medical Spa
Permanent Cosmetics Consent

Name_____Date_____DOB_____

Address_____City_____State____Zip_____

Home/Cell _____ Work_____ Email_____

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

Procedure(s):_____

Number of Visits Required:_____Cost of Procedure(s):_____

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 known and unknown complications and consequences associated with this type of cosmetic procedure, including but not limited to: infection, scarring, inconsistent color, and spreading, fanning or fading of pigments. Corneal abrasions are a rare side effect, especially if I rub or scratch my eyes or apply contacts too soon after any eyeliner procedure. I understand the actual color of the pigment may be modified slightly, due to the tone and color of my skin. I fully understand this is a tattoo process and therefore not an exact science, but an art. 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). X____

There is a possibility of an allergic reaction to pigments. A patch test is advisable however it does not ensure a client will not have an allergic reaction. I consent_____(initial) or waive_____(initial) the patch test. If waived, I release the technician from liability if I develop an allergic reaction to the pigment.

I understand that if I have any skin treatments, 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_____

I have received pre- and post procedure instructions and I will strictly adhere to such 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 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 cosmetic tattoo work done.

Client:_____Date_____

Technician_____Date_____