

dermatech

PERMANENT COSMETICS & PROFESSIONAL SKIN CARE EXPERTS

Today's Date ____/____/____

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

Ethnic Background, please include all nationalities _____

Address _____ Apt. # _____ City: _____

State _____ Zip _____ Home Phone (____) _____ Cell (____) _____

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

Office use only

Fee: \$ _____ \$ _____ \$ _____ \$ _____ \$ _____ \$ _____

Terms _____ Paid _____ Deposit _____

Balance _____ Charge _____ Cash _____ Check _____

Practitioner _____ **Signature** _____

Trainee [] **Apprentice** [] **Signature** _____ **Date of training** ____/____/____

ALLERGIES: Please check, circle & describe if you ever had an allergic reaction to any of the following

- | | |
|--|--|
| <input type="checkbox"/> Antibiotic Ointments (i.e., Neosporin, Bacitracin, Polymyxin, etc.) | <input type="checkbox"/> Seasonal (Trees, pollen, hay fever) |
| <input type="checkbox"/> Novocain, Lidocaine, Epinephrine | <input type="checkbox"/> Latex Rubber |
| <input type="checkbox"/> Cosmetics | <input type="checkbox"/> Metals, Other |

Describe reaction _____

Practitioner Signature _____ **Date** ____/____/____

GENERAL MEDICAL (Check all of the following that apply and describe if "yes")

	<u>YES</u>	<u>NO</u>
Have you ever had a fever blister, <i>even one</i> in your life? Get regular canker sores?		
Are you pregnant or nursing?		
Do you have glaucoma or other eye disease or disorder?		
Have you ever had any eye trauma?		
Have you had a vision correction procedure such as RK or Lasik surgery in the last 3 months?	_____	_____
Are you considering having vision correction procedures in the next 2 months?		
Are you prone to eye infections (i.e., conjunctivitis/pink eye)?		
Do you have a hyperactive thyroid or Grave's disease?		
Are you on Accutane, or have you taken it within the last year?		
Do you have a heart disease? _____	_____	_____
Have you had heart attack within the past year? When? _____		
Do you have Mitral Valve Prolapse, Valve Implants, a Pacemaker or Stents ? _____	_____	_____
— Prior to dental procedures, do you receive antibiotic therapy? _____	_____	_____
— Are you presently on chemotherapy or a prophylactic dose of chemotherapy?		
Are you on steroids?		
Recent surgeries? If yes, describe: _____ _____	_____	_____
— Have you had a Joint Replacement or Organ transplant? If yes, describe: _____		
Are you an insulin diabetic?		
Do you have seizures or fainting spells? _____	_____	_____
— Do you bruise or bleed easily?		
Do you have problems with healing? _____	_____	_____
— Camouflage only: Do your scars heal in a raised manner?		—
Camouflage only: Do your scars heal in a darker color?		
Do you have keloids? Where? _____		
Do you use Retin-A, Glycolic Acid, Vitamin C or other exfoliants?		
Do you have a dermatological disorder(s)? Name of dermatological disorder(s) _____	_____	_____
If yes, is this disorder presently active or in a flare-up?		—
Do you use a tanning bed and are you currently tan in the area(s) to be treated?		
Signature of Practitioner _____ Date ____ / ____ / ____		

	<u>Yes</u>	<u>No</u>
Are you on anti-depressants, anti anxiety medication or treatment for Bi-Polar disorder?		
Do you have hemophilia or other clotting disorders?		
Do you have an autoimmune disease/disorder? Name of autoimmune disease/disorder _____		
Have you ever had hepatitis? What type? Please circle: Hepatitis A Hepatitis B Hepatitis C When were you last tested? Are you in good health at this time?		
Do you have any pre-existing nerve damage in the area that I will be working?		
Do you have any tattoos? Name any of the colors that are sensitive to the sun or rise up in the sun.		
Are you on a blood thinning medication?		
Do you have Trichotillomania? (Pulling of hair, brows or lashes)		
Do you have Alopecia Totalis (total) or Alopecia Areata (local)?		
Do you tint your brows?		
Do you tint your lashes?		
Have you had Gore-Tex implants? If yes, where? _____		
Have you had Botox? When? _____ - Have you had fat transfer injections? If yes, where? _____		
Have you had any other aesthetic procedures, even in the form of cosmetic surgery? If yes, Describe procedures? _____ When? _____ _____ - If yes, are you happy with the results?		
Are you planning cosmetic surgery in the near future? What surgery/surgeries are you planning? _____ When? _____		
Have you ever had a chemical peel? What type of peel? _____ _____ - Have you had laser treatments? What type of lasers and why? _____		
Do you practice any outdoor activities regularly? If yes circle which ones? Tennis Golf Gardening Boating Swimming Skiing Walking Other		
If you are presently under a physician's care for any condition, please describe: _____ _____ _____		

Physician's Name _____ Address _____
Phone (_____) _____
Specializes in _____

Practitioner Signature _____ Date ____/____/____

Client Name _____

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

INFORMED CONSENT TO PROCEDURE

Initial:

- 1. 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. _____
- 2. I have received, reviewed and understand the pre & post-procedural instructions as given to me and agree to follow them. _____
- 3. 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. _____
- 4. I understand that the color selection and color results in all procedures are not an exact science. _____
- 5. I have been advised not to drive a motor vehicle for eight (8) hours following an eyeliner procedure. _____
- 6. If I insist on driving, I waive all responsibility to my practitioner and Andrea Crane, R.N. and I assume full responsibility that I can see to drive, perfectly. _____
- 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 Andrea Crane, R.N. 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

Client Name _____

physician or an emergency room, **immediately**.

17. If I had permanent cosmetics performed previously by another practitioner, I do not hold Andrea Crane, R.N. responsible for future allergic reactions or contraindications.

18. SCRATCH TEST CONSENT:

I have received a patch test on _____(date) and have had no adverse side effects. The patch test was completed prior to the procedure and releases Andrea Crane, R.N. from any liability related to any allergies or other reaction to applied pigments.

The Scratch Test was waived because of: _____

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** ____/____/____

Re-Consent Form For Touch Up Visits

Initial

1. 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.

2. I have received, reviewed and understand the pre & post-procedural instructions as given to me and agree to follow them.

3. 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.

4. I understand that the color selection and color results in all procedures are not an exact science.

5. I have been advised not to drive a motor vehicle for eight (8) hours following an eyeliner procedure.

6. If I insist on driving, I waive all responsibility to my practitioner and Dermatech Inc. and I assume full responsibility that I can see to drive, perfectly.

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 simply determines that it is a time for a touch-up visit.

11. I realize this is an elective cosmetic procedure, not an exact science, 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 Andrea Crane, R.N. 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 physician or an emergency room, **immediately**.

17. If I had permanent cosmetics performed previously by another practitioner, I do not hold Andrea Crane, R.N. responsible for future

If client under the age of 18, signature of guardian _____

allergic reactions or contraindications.

18. Are you Pregnant?

Yes No

19. Is your Health History the same as your last visit?

Yes No

If No, please specify and also list any new medications and why they were prescribed to you.

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** ____/____/____