Consent to Application of Semi-Permanent Makeup Procedure

Client Name: _____

Date of Birth: _____ (MM/DD/YY)

Address: _____

Phone: _____ Email: _____

Do you have any known allergic reactions or sensitivities to any topical or local anesthetics?	Yes	No
Do you have any allergies {i.e. Polysporin, Bacitracin, Neosporin, Latex, etc.)?	Yes	No
Are you allergic to lidocaine or any other numbing agents?	Yes	No
Are you currently pregnant or breastfeeding?	Yes	No
Do you bruise easily?	Yes	No
Do you have any heart conditions or high blood pressure?	Yes	No
Do you have or do you think it is possible that you have any blood-borne infectious disease such as HIV or Hepatitis?	Yes	No
Do you have any serious medical conditions?	Yes	No
Does your skin swell easily?	Yes	No
Do you have diabetes, are you currently on any form of immunosuppressant therapy, or do you have any condition that may delay healing?	Yes	No
Do you suffer from any form of Hyperpigmentary skin condition?	Yes	No
Do you have any known personal history or family history of Methemoglobinemia?	Yes	No
Have you ever had a Herpes Simplex Type 1 infection?	Yes	No
Do you use Retin A or Hydroxyl (Glycolic) Acid preparations?	Yes	No
Are you prone to keloid scarring, hypertrophic scarring, or any other form of excessive scarring condition?	Yes	No
Do you have a bleeding disorder or take blood thinners?	Yes	No
Are you allergic or sensitive to any metals?	Yes	No
Have you had any form of cosmetic or surgical procedure, Radiotherapy, or Chemotherapy at any time within the last 6 months? (Botox, injections, laser therapies, facelifts, etc.)	Yes	No
Do you have any chronic or acute eye disease?	Yes	No

- The UNDERSIGNED acknowledges that _____ has explained the nature of the procedure, including the risks and dangers inherent therein.
- I HEREBY CONSENT to _____ performing cosmetic tattoo treatment and procedures on me and in consideration of their doing so, I hereby release and forever discharge _____ from all demands, damages, actions, or causes of action arising out of the performances of said treatment procedures, which I, my heirs, executors, administrators or assign can, shall or may have.
- There will be no refund on any treatment.
- I hereby consent to _____ taking photographs of the undersigned both before and after any procedures being undertaken by _____.
- It is further acknowledged that the undersigned authorizes _____ to use such photographs in compiling albums of its various clients for the purpose of showing potential clients the procedures completed.
- This release shall be deemed to have been made and shall be constructed in accordance with the Laws of the State of Ohio.

Client Signature: _____Date: _____

Technician Signature: _____Date: _____