

Confidential Personal and Medical Profile

Name:		Email:		Date:	
Address:			City:		St: Zip:
Home #:		Cell #:		Cell Ph Carrier:	
Referred By:				Date of Birth:	

1. To avoid unforeseen complications, please answer the following questions; if yes explain:

Y N	Are you over the age of 18?
Y N	Have you had any aspirin or blood thinning products within the last 7 days?
Y N	Any mood altering drugs within the last eight hours?
Y N	Do you have any history of cold sores, herpes, or fever blisters on the lips?
Y N	Have you had a chemical or laser peel? If so, when?
Y N	Do you have problems with healing?
Y N	Previous problems with tattoos or has your physician advised you not to have a tattoo at this time?
Y N	Are you currently undergoing radiation or chemotherapy?
Y N	Are you currently using Retin-A or "Alpha Hydroxy" skin care products? Accutane Treatment?
Y N	Are you allergic to any metal? (e.g. Can only wear 14K gold.)
Y N	Have you ever had any permanent makeup procedures before?
Y N	Medication, including immunosuppressive, such as anti-inflammatory or steroids?
Y N	Are you sensitive to or get withdrawal symptoms from caffeine products?
Y N	Are you allergic to topical antibiotic preparations? (e.g. Polysporin, Bacitracin, Neosporin, or Petroleum)
Y N	Are you allergic to topical numbing solutions? (e.g. "Caine" family of drugs)
Y N	Is there any history of skin diseases or remarkable skin sensitivities?
Y N	Are you presently taking Vitamins A and/or E in any form?
Y N	Are you pregnant or nursing?
Y N	Are you required to take antibiotics during dental or invasive medical procedures?
Y N	Do you wear contact lenses? If yes, I understand they must be removed during my eyeliner procedure, until the next day.

2. Please check all that pertain to you:

<input type="checkbox"/> Heart conditions	<input type="checkbox"/> Epilepsy/ Seizures of any kind	<input type="checkbox"/> Alopecia
<input type="checkbox"/> Chest pains	<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Hypertrophic scar formation
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Keloid scar formation
<input type="checkbox"/> Stroke	<input type="checkbox"/> Refractive eye surgery	<input type="checkbox"/> Accutane treatment
<input type="checkbox"/> Tendency to bleed excessively from minor injuries	<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Hyper-Pigmentation (Darkening of the skin)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tendency to rub your eyes	<input type="checkbox"/> Allergies to makeup
<input type="checkbox"/> Hepatitis/ Jaundice/ HIV	<input type="checkbox"/> Ocular herpes	<input type="checkbox"/> Botox or injected fillers
<input type="checkbox"/> Cancer (what type?)	<input type="checkbox"/> Shingles (where?)	
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Trichotillomania	

3. Please explain any checked question, list any other medical conditions, and list all your medications, use other side if needed:

4. If you are currently under the care of a physician, please give his name and phone number:

Dr. Name:	Phone #
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Post Procedural Care

FAILURE TO FOLLOW POST-PROCEDURE INSTRUCTIONS MAY RESULT IN LOSS OR DISCOLORATION OF PIGMENT.
PLEASE DO NOT HESITATE TO CALL IF YOU HAVE ANY QUESTIONS

EYELINER

Expect light to moderate swelling and redness for a couple of days. Ice packs may be used to reduce puffiness especially in the mornings. Use eye wash every couple hours for the first two or three days. Use as needed on the following days to soothe the eye. Always dry your lashes after each rinse, this will ensure thin scabs. No makeup or eye creams to avoid contamination and irritation of the area.

EYEBROWS / LIP and all OTHER PROCEDURES

Expect light to moderate swelling, thickness, and/or redness for one to two days following the procedure. Apply product to area for 10 to 15 minutes at a time, then gently wipe product off. Area needs to dry out fully before the next application. Do this for 5 days. After 5 days product can be left on.

RECOMMENDED PRODUCTS

EYE WASH / SALINE SOLUTION (Sterile Water)
(Sold at CVS)

ARNICA (Inhibits Bruising) (

HEALSTICK

AQUAPHOR

LIPROTEK

1. Wash hands often to avoid a bacterial infection in the treated area.
2. Do not rub or stretch your eyes while healing! This will cause pigment migration around the eye.
3. Do not use any Retin-A or Glycolic Acids while healing!
4. Do not use Peroxide or Neosporin on ANY areas!
5. Do not scrub or pick treated areas!
6. Do not expose area to sun or tanning beds!
7. Avoid facials, swimming, and/or whirlpools for at least five days!
8. Do not dye or tweeze eyebrows one week before or after the procedure!
9. No vigorous exercise for 24 hours!
10. Avoid blowing your nose with a lip procedure to prevent staph infections.
11. No makeup on the area.

* If signs of infection occur (oozing, heat, increased swelling, redness in eyes) go to a physician immediately.

- You may wash your face normally with a gentle cleanser
- It is normal to lose approximately 1/3 to 1/2 of the color during the healing process.
- After initial procedure, the color may be a shade too dark (extra pigment on the surface); in six days it will appear too light (the healing skin is opaque and hides the color); after ten days the color will show more (the skin becomes translucent).
- Your permanent cosmetics will appear softer when completely healed because you are viewing the color through the layers of the skin.
- In the event of a CAT scan or MRI, please inform your physician of your Iron Oxide Permanent Cosmetics as some pulling or burning sensation may occur during the procedure.

The known possible complications from micropigmentation are:

- Redness
- Swelling
- Puffiness
- Bruising
- Dry Patches
- Tenderness

By initialing this document I acknowledge that I have received a copy of these instructions and will follow them to the best of my ability. If I deviate from the instructions I will be responsible for the consequences of my actions, whatever those may be.

Picture Release

Photographer :	Tai Brows
Please read and answer the following statements:	Initial
I understand the taking of photographs, before and after the procedures is required.	
I acknowledge that Tai Brows Makeup, Inc <i>may</i> use my pictures for advertising purposes.	
I prefer that my pictures were used for legal reasons only.	

For valuable consideration, I hereby irrevocably consent to and authorize the use and reproduction by you and/or anyone authorized by you, of any and all photographs which you have this day taken of me, negative or positive, and of which the proofs are hereto attached, for any purpose whatsoever, without further compensation to me. All negatives and positives, together with the prints, shall constitute your property, solely and completely. I assign to you the right to copyright photography.

Herpes Simplex Release

IF YOU'VE EVER HAD A COLD SORE IN YOUR LIFE you have the herpes virus in your system and must be on medication before, during and after all lip procedures. If no medication is taken the outbreak can be severe and cause swelling with blisters and pain. This can possibly leave you with scar tissue damage and loss of feeling. It will also result in a loss in the permanent makeup color.

If you are having a lip procedure and have any history of cold sores, fever blisters or herpes simplex, you will be required to contact your physician to obtain the proper prescription medication to prevent such outbreaks. Many physicians prescribe medication to be taken two days before micro-pigmentation and four days during the healing period or as physician prescribes.

This medication *must* be taken at *every* lip procedure. If you do not take it each time it may result in a breakout.

I understand the consequences and will be responsible for contacting my doctor and receiving the right medication to prevent a herpes breakout.

Clients Signature: _____ Date: _____

Informed Consent for Permanent Makeup

I, _____, acknowledge by signing below, that I have been given the full opportunity to ask any and all questions which I might have about the obtaining of any permanent cosmetic procedures from Tai Brows Makeup Inc. and/or any associates. I also acknowledge that all of my questions have been answered to my full and total satisfaction. I specifically acknowledge that I have been advised of the facts and matters set below, and I agree as follows:

Please read and initial the following statements:	Initial
I waive or consent the patch test. If I waive, I release the technician from liability if I develop an allergic reaction to the pigment.	
I understand that the process used to apply color is not a one-step process and requires subsequent visits to achieve desired results. I further understand that if this is my first time receiving permanent makeup that the fee includes my first visit only . Touch ups are recommended 4-8 weeks later at an additional cost. Based on skin types and post-op care, results may vary from person to person. Also, Subsequent maintenance touch-ups are scheduled as needed and may vary from six months to three years. Fees for maintenance visits are found on the Procedure Fee document.	
I understand that with time, pigment can, and will, fade and change color according to metabolism, skin type, and age, and exposure to sun, smoking, alcohol, medications, Retin-A, and Glycolic acids.	
I acknowledge that no guarantees have been made to me concerning the results of this procedure and that the professional recommendation is a NATURAL LOOK. risks associated with permanent makeup may cause fading, fanning, or spreading	
I understand the nature of the Permanent Makeup (Tattoo) procedure and it has been explained to me as having the usual risks inherent in the procedure and the possibility of complications during and following its performance. I understand there may be a certain amount of discomfort or pain associated with the procedure and that other adverse side effects may include minor and temporary bleeding, bruising, redness or other discoloration and swelling; pigment migration may occur; fever blisters may occur on the lips following a lip procedure in individuals prone to this problem, fading or loss of pigment may then occur. Secondary infection in the area of the procedure may occur; however, if properly cared for, occurrence is rare.	
I acknowledge that complications are always possible as a result of the Permanent Makeup procedure, particularly in the event that post-procedural instructions are not followed.	
I have received and acknowledged pre- and post-procedure instructions and agree to strictly adhere to such instructions.	
I acknowledge that the procedure will result in a permanent change to my appearance and that no representations have been made to me as to the ability to later change or remove the result.	
I accept responsibility for determining the color, shape, and position of the pigments that will be applied. I understand the actual color of the pigment may be modified slightly due to the tone and color of my skin.	
I understand that future laser treatments or other skin-altering procedures, such as plastic surgery, implants, and/or injections may alter and degrade my Permanent Makeup. I further understand that such changes are not the fault of the practitioner and/or any of the practitioner's associates. I further understand that such changes in my appearance may not be correctable through further Permanent Makeup procedures.	
I realize that my body is unique and the practitioner or any of the practitioner's associates cannot predict how my skin may react as a result of the procedure.	
I acknowledge that it is not reasonably possible to determine whether I might have an allergic reaction to any of the pigments, dyes, topical preparations, or processes used in the procedure; and I agree to accept the risk that such a reaction is possible I have informed the practitioner of any existing problems.	
I acknowledge that the obtaining of Permanent Makeup procedure(s) is by my choice alone, and I consent to the application of the procedure and to its attendant risks, and to any actions or conduct of the practitioner and/or any of the practitioner's associates reasonably necessary to perform the procedure(s).	
For the purposes of education or assistance, I consent to the admittance of authorized observers to the procedure(s).	

Informed Consent for Permanent Makeup

I give my consent to Tai Brows Makeup, Inc to confer with my physicians for medical information required for the safety of my procedures.	
I agree to accompany my practitioner to the emergency room in the event of an accidental needle stick with my needle, take a blood test for their safety and disclose all test results to my practitioner.	
I am aware that if an infection occurs after I have received Permanent Makeup that I should see my primary physician or go to the emergency room IMMEDIATELY.	
I fully understand this is a tattooing process; therefore, not a science but an art form and that it is non-refundable.	
I witnessed un-packaging and use of new sterilized needle	

Consent to Procedure & Fees

I hereby request and consent to the application of permanent color and consent to have the following procedures performed by Tai Brows Makeup Inc. Done by practitioner _____

Type of Procedure				
New Client Procedures	New Client Touchups	Existing Clients Touchups	Packages	Per Appointment Procedures
Price:	Price:	Price:	Price:	Price:
Understanding the Process:				Initial
I accept that prices are subject to change				
I understand that perfecting visits must be completed in a three month period or subject to additional charges.				
I understand that lifestyles can affect the length of time required between touchups.				
I understand that permanent makeup is a multi-session process and can take many layers to complete my look.				

NOTE: All services are priced at the practitioner's discretion, she reserves the right to price clients as she sees fit. Prices may increase.

I have read and understand the contents of each paragraph above. I acknowledge this is a contract and that I have received no warranties or guarantees with respect to the benefits to be realized from, or consequences of, the aforementioned procedure(s). I further acknowledge that at the time of signing this consent to this procedure(s), I was of sound mind and capable of making independent decisions for myself.

Clients Signature: _____ Date: _____

Practitioner: _____ Date: _____

NOTES:	
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Softap Pigment Color #

Prong #