Permanent makeup

Micro-pigmentation consultation sheet

Confidential information

Name: Date: / / /
Address:
City: Province: Postal code:
Phone: Email:
Profession: Date of Birth: / / /

Expectations for the region

General questions

How did you learn about dermo-pigmintation?

What do you see as the advantages and disadvantages?

What do you want to change and why?

Do you have any questions that would like to be answered?

What is your daily make-up routine?

Treatment Plan

To pigment the target of_____, we estimate this may take _____ session(s).
The client agrees to not use other treatments during the procedure and the healing process.
The price of the first treatment is based on a notice of a unit price of _____.
The client must follow the instructions for treatment after care and contact the technician.

The signature is requested to confirm the client and the technician have discussed the treatment plan and that they agree that the information is fully understood.

Client Signature Date

Client Signature Date

DATE PIGMENT NEEDLE COMMENTS #PASS VISIT

I confirm to be satisfied with my permanent makeup and I understand that the steps to follow in order to finalize the permanent makeup

Client Signature:
Date:

Consent for Permanent makeup

I authorize and retain the services of _____ for permanent makeup on my eyebrows. I understand that approved botanical pigments will be implanted in the upper layers of the epidermis just above the dermis. I understand the steps and semi-permanent nature of this technique, as well as the risks associated with it that have been explained to me beforehand such as swelling, redness, slight bleeding at time of execution. I also consent to the use of selected and approved topical anesthetics. I know that permanent makeup is an inaccurate science and that the result cannot be guaranteed. I know that if my skin is dark, the pigments will not be as bright as on fair skin. By semi-permanent nature, the term cares from a few years (1 to 3 years). I know that my permanent makeup will gradually fade during the first weeks and will stabilize thereafter. I understand that the technician does not have control over this duration and

that the colour degeneration will probably require alterations, provided that these are carries within 3 years.

After this time, retouching will be considered a new application. I confirm that I do not have any health problems that may present contradictions to the performance if permanent makeup, and this as confirmed in my health card. I know that unidentified health problems could influence the end result of permanent makeup. I am not under the influence of drugs or alcohol. To the best of my knowledge, I am therefore in good physical and mental health. I agree to follow all indications and post-treatment care that are explained and recommended to me. I asked the questions necessary for my engagement and I received clear and satisfactory explanations. I agree to pay the amount required for the execution of permanent makeup. This amount is non refundable. I, the undersigned, waive any remedies, charges and actions for damaged, indemnity payments, claims of errors, errors and omissions or otherwise according to law. This also applies to other permanent makeup applications is applied to the pigment area.

This is included in your initial price: YES NO
I have read and understand the whole text above.

Client signature on the_____ month of_____ year_____

Signature:_____

General Health Sheet

It is important to correctly answer the questions to ensure that you receive appropriate care, taking in to account the peculiarities and your health.

Are you generally healthy? YES NO

Are you pregnant? YES NO

Do you wear contact lenses? YES NO
Are you diabetic? YES NO

Do you have heart problems? YES NO

Do you have problems with blood pressure? YES NO

Do you have problems with the thyroid gland? YES NO

Do you use anticoagulants(Asprin, Ibuprofen, Coumadin)? YES NO

Do you have HIV/AIDS? YES NO

Do you have a disorder if your immune system? YES NO

Are you a carrier if hepatitis B or C? YES NO

Do you bruise easily? YES NO

Are you nervous or anxious? YES NO

Do you use Retin A, Hydroxyl or Botox? YES NO

Have you had facial cosmetic surgery? YES NO

If yes, where and when?_____

Do you have tattoos? YES NO

Do you expose yourself to the sun? YES NO

Do you practice a sport? YES NO If yes, where and when?_____

Do you have any allergies? YES NO. If yes, where and when?_____

Do you take any medication? YES NO

Are you hemophilia? YES NO

Have you ever had problems such as:

Skin cancer/Melanoma Rosacea Acne Hyper pigmentation Hypo Pigmentation Scar Keloid Eczema psoriasis Lupus

Do you agree that your photo before and after will be used for future publications? YES NO
I, undersigned, acknowledge the importance of the information I have provided to ensure the proper functioning of the care I will receive. Accordingly, I submit that this information is accurate and truthful.

Client signature on the_____ month_____ year_____

Signature:_____