Today's Practitioner ______________________________ **Today's Date** _____/____/_____

** I am aware of the current COVID -19 Pandemic and acknowledge that there is a risk, however slight, by consenting to having cosmetic tattooing procedure performed and agree to assume that risk.

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

Address: ____ Apt. _________________________

City:____

Home Phone: (_____)_________________ Mobile: (____)_____________________________

Occupation: ________________________ 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 Areola Correction Lightening

List all medications you are presently taking

Name of Drug	**Mg. or mcg**	**How many each day**	**Why it was prescribed**

List all medications you took in the last six months that you are no longer taking:

Name of Drug	**Mg. or mcg**	**How many each day**	**Why it was prescribed**

Client Signature: Date _____/_____/_____

Practitioner Signature: Date _____/_____/_____

Dr. Signature: Date _____/_____/_____ (if required)

GENERAL MEDICAL Client Name: ___________________________

Do you have? (check all that apply)

Fever Blisters/Cold Sores (Ever, even one time)
Glaucoma or other eye disease/disorder
Grave's Disease
Heart Disease
Mitral Valve Prolapse
Valve Implants
Pacemaker
Stents
Diabetes requiring insulin
Problems with healing
Keloids
Seizures
Dermatological Disorder
If so, what? ___________________
Active or in Flare-ups? ___________
Hemophilia or Clotting Disorder
Autoimmune Disorder
Pre-existing nerve damage
Tattoos: Colours you are sun sensitive to:
____
Trichotillomania (pulling of hair, brows, lashes)
Alopecia Totalis or Areata
Allergies
List: __________________________
____
____
____

Do you use? (check all that apply)

Accutane (currently or within the past year)
Antibiotics prior to dental procedures
Steroids
Retin-A, Glycolic Acid, Vitamin C or other Exfoliants
Tanning Beds
Eyebrow Tinting
Eyelash Tinting
Latisse
Botox When? ____________________
Chemical Peels When?_____________
Chemotherapy or Prophylactic dose of Chemotherapy
Blood Thinners

Have you had? (check all that apply)

Fever Blisters/Cold Sores (Ever, even once)
Eye Infections (Are you prone to them)
Vision Correction Procedure (Lasik, RK) within the past 3 months
Heart Attack - When? _________
Joint Replacement, Organ Transplant
Eye Trauma
Seizures
Fainting Spells
Hepatitis - What Type: _________
Hepatitis Test - When? _________
Fat Transfer Injections - If yes, where? _________
Gore-Tex Implants - If yes, where?_________
Aesthetic or Cosmetic Procedures If yes, where? _________
Laser Treatments
What type & why? __________

Lady Ink

Are you? (check all that apply) Pregnant Planning cosmetic surgery If so, what & when? ______________________ Currently under the care of a physician Describe: ______________________________		
Do you practice outdoor activities? Circle all that apply Tennis Swimming Golf Skiing Gardening Walking Boating Other		Physician's Name: _____________________ Address: ____________________________ Phone: ______________________________ Specialty: ____________________________

Practitioner Signature: Date _____/_____/_____

Dr. Signature (if required): Date _____/_____/_____

INFORMED CONSENT TO PROCEDURE

PROCEDURE TYPE:_______________________________ DATE: ______________________

Some Potential reactions following procedure: scabbing, flaking, pigment loss, infection (if not properly cared for), swelling, itching, redness

1. Are you pregnant or nursing? Yes No

INITIAL

2. I absolutely understand and accept that such procedure is a process, often requiring multiple applications of colour to achieve desirable results and the 100% success cannot be guaranteed. ______________
3. I have received, reviewed and understand the pre-procedural instructions as given to me and agree to follow them. ______________
4. 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 colour. ______________
5. I understand that the colour selection and colour results in all procedures are not an exact science. ______________
6. 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. . ______________
7. 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. ______________
8. If I am a lens wearer, I realize that I must keep my lenses out the day of an eyeliner procedure. ______________
9. I understand that this procedure will fade and this fading can alter the original pigment colour and that this determines that it is a time for a touch-up visit. ______________
10. I realize this is an elective cosmetic procedure and is not medically necessary. ______________
11. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, scabbing, bruising, redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment. ______________
12. 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 ______________

13. I give my consent to Lady Ink, LLC to confer with my physicians for medical information required for the safety of my procedures. ________________

14. 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. ________________

15. 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. ________________

16. I am aware of the current COVID -19 Pandemic and acknowledge that there is a risk, however slight, by consenting to having a body art procedure performed and agree to assume that risk. ________________

ACCEPTANCE:

I have read and understand these risks listed above and they have been explained to me. I certify that the information in the above questionnaire is accurate and my questions have been answered.
I acknowledge due to the current state of events with COVID -19 I am more susceptible

Please read all questions thoroughly before signing.

Client Signature:	Date _____/_____/_____
Practitioner Signature:	Date _____/_____/_____
Dr. Signature:	Date _____/_____/_____ (if required)

13 Corriedale Lane, West Melton, Canterbury

PHOTOGRAPH AND PUBLICITY RELEASE FORM

I, ____, give my permission to use my likeness, image, and/or appearance as such may be embodied in any pictures, photos, video recordings, digital images, and the like, taken or made on behalf of Lady Ink. I agree that Lady Ink, has complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with the Lady Ink's mission. These uses include, but are not limited to illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials in any medium now known or later developed, including the Internet. I acknowledge that I will not receive any compensation, etc. for the use of such pictures, etc., and hereby release Lady Ink and its agents and assigns from any and all claims which arise out of or are in any way connected with such use.

I have read and understood this consent and release.

I give my consent to Lady Ink to use my likeness to promote the company, and/or their activities.

DO NOT USE FULL FACE

Client Signature: Date _____/_____/_____

Print Name:

13 Corriedale Lane, West Melton, Canterbury

SHAPE / COLOUR REQUEST FROM CLIENT

I ______________________________________ am electing to choose my own colour and/or shape for my __________________________________ procedure.

My Technician has explained the pros and cons of me choosing my own design and/or colour. I am aware that the visual outcome regarding design/shape and/or colour is based by my choices.

Client Signature: Date _____/_____/_____

Print Name: