PERMANENT MAKEUP
RELEASE FORM

Please READ and complete the release form. Please be certain that the address and telephone numbers are correct. THANK YOU!

Print Name:_____ Date of Birth:_____
Address:_____
City, State, & Zip:_____
Phone Number: ( )-_____E-Mail_____

DISCLOSURE AND CONSENT FOR PIGMENTATION IMPLANTION FOR
EYELINER, EYEBROWS, LIPS, AND SCARS

You have the right to be informed so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to frighten you, it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

I understand that no warranty to guarantee has been made to me as a result of this procedure. The procedure may not reach my expectations. There may be risks and hazards related to the performance of this procedure planned for me. I realize that there is potential for discomfort during and after the procedure. There is a possibility of bleeding and allergic reactions to the dye. I also understand that the tattooing is permanent, however, it may fade with time. I understand the misplacement of the dye can occur under rare circumstances requiring excision of the misplaced dye, in rare cases; there may be permanent loss or growth of eyelashes.
I understand a skin test may be performed if there are questions of allergy to the dye and the test and reactions, if they are to be used, they have been explained to me. I am free from drug and alcohol use or any other substances. I am not pregnant: _____(initial and date)

I understand that due to different genetics, very few people have 100% even facial bone structures and facial features.
My original hair color _____ and color now is_____.
My skin color is_____ and color now is_____.
My original eye color is_____ My own lip color is_____.

Brows
I design my own eyebrow style.( )
I order my PMU artist to do the eyebrow as I have drawn. ( )
I let my PMU artist design my eyebrow and I have approved it.( )

Eyeliner(Upper, Lower)
I want my (upper, lower) eye line to be very (thick, thin).
I let my PMU artist design my eyeliner and I have approved it. ( )

Lips and/or Lip liner
I want my lip line to be very (full, thinner than usual, thicker than usual).
I let my PMU artist design my lips for me and I approved it. ( )

What is your desired out come with this procedure(s)?_____

I understand that many factors can affect the out come of this beauty service, which include, but are not limited to, issues such as stress, hormonal changes and certain medications.
I understand that PMU attempts to improve, enhance, accentuate and beautify.
I have been advised of the benefits and temporary discomforts.
I hereby consent to receive PMU beauty service and the above statements have been fully understood by me and that it was preceded by an explanation as to what is to be expected.
I have read, fully understood, and agree to all of the above statements.

Client Signature & Date: _____

Artist Signature & Date: _____

MEDICAL HISTORY

Please answer the following questions.

Do you presently have, or have ever had:

1. *Hepatitis B? Yes___ No___*
2. *Hepatitis C? Yes___ No___*
3. *HIV/AIDS? Yes___ No___*
4. *Diabetes? Yes___ No___*
5. *History of hemophilia or any other blood disorder/disease? Yes___ No___*
6. *Skin disease or skin lesions? Yes___ No___*
7. *Sensitivities to soap, disinfectant, topical bacterial ointment (Neosporin) etc.? Yes___ No___*
8. *History of allergies or adverse reactions to pigments, dyes, latex, etc.? Yes___ No___*
9. *Tuberculosis? Yes___ No___*
10. *Immune disorders? Yes___ No___*
11. *History of heart murmur or any heart disease/condition? Yes___ No___*
12. *Scarring (keloids)? Yes___ No___*
13. *History of epilepsy, seizures, fainting, or narcolepsy? Yes___ No___*
14. *History of taking medications such as anticoagulants that thin blood and/or interferes with blood clotting? Yes___ No___*
15. *Are you now under the influence of alcohol or drugs? Yes___ No___*
16. *If Yes, What? _____.*
17. *Are you currently taking any anti-depressants? Yes___ No___*
18. *Are there any other medical conditions which may affect your PMU healing process? Yes___ No___ If so, what? _____*
19. *Do you have trouble numbing when receiving dental work? Yes___ No___*
20. *Are you seeking micro pigmentation in order to correct the effects of an accident, medical procedure or medical condition ? Yes___ No___*
21. *If Yes, What? _____.*
22. *FEMALES: Are you pregnant or breast feeding/nursing Yes____ No ___*

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE CONDITIONS, IT IS RECOMMENDED THAT YOU CONSULT WITH PERSONAL PHYSICIAN OR DENTIST BEFORE ANY PERMANENT COSMETIC PROCEDURES ARE PERFORMED.

Signature:_____

Print Name: _____

Date: _____

Artist:_____

For permanent Makeup Site(s):_____

Comments:_____

MICRO-PIGMENTATION IMPLANTATION REPORT

Patient Name: _____ Date: _____

Office/Location: _____

Scratch Test: _____ Location: _____

Date: _____ Reaction: Positive ____ Negative ____

Procedure Type: (A) Scar Camouflage (B) Eyeliner (C) Eyebrows
(D) Lip Liner (E) Full Lip (F) Wet Line

Pigments: Nouveau Contour _____ SofTap _____ Other _____

Needle Sizes: 1Liner 3Liner 4Flat 5Liner 7Round 9Magnum Other

Anesthetic: DOTC Blue_____ TAC/Sol_____ Other_____

Prep: Alcohol_____ Baby Wipe_____ Other _____

Position: Supine _____ Sitting _____ Prone _____ Lateral _____
Other _____

Post Procedure Medication: Bacitracin Ointment _____ Vaseline _____
Bag Balm _____ Other _____

Eye Drops: Collyrium _____ Saline _____ Other _____

Pre-Procedure Check List:

Allergies_____
Consent _____
Photos _____
Derma Tech _____
Arrival Time _____
Departure Time _____

YOUR NEW PERMANENT MAKEUP
"POST OP"
INSTRUCTIONS

On the first day your permanent makeup will darken because the pigments are beginning to oxidize and during the next few days they will lighten. It is very important that you keep the treated areas moist by using the Vaseline.

After the first week, the top layer of the epidermis will shed. This means that your procedure is starting to heal. Once this top layer peels away, you may shed a few more layers of color not noticeable to the naked eye. All of the procedures will soften to a natural look over the next few weeks.

Lips take the longest to heal and will discard the top layer of color three to four days after the procedure. The next few days there is no color visible, just a clear shedding of the second layer. Over the following four to six weeks the color will slightly darken. After eight weeks the color that is visible is the color your body has retained. The lip line will be repeated during your touch up. Remember lips heal the slowest, so please be PATIENT. Stay out of the sun, hot tubs, swimming pools and the ocean. Salt water/saline, chlorine and sun exposure can be your worst enemies!

Eyeliner may dissipate to a certain degree and you may form a scab if the area is not kept moist. Most clients hold approximately 80% of the pigment for this procedure. We can thicken and darken your eyeliner when you return for your touch up if necessary.

Eyebrows are very dark for the first 24 hours after the procedure. Don't be alarmed. Over the next few days they will lighten considerably. The eyebrows will vary in color during the healing process. We will darken and add hair strokes at the time of your touch up if necessary.

Everyone heals differently and color retention varies per individual. I am sure you will be very pleased and remember…YOU LOOK GREAT!!

Signature:_____ Date: _____

Client Information Sheet

LAST NAME: _____ FIRST NAME: _____ MI: _____
ADDRESS: _____CITY:_____STATE:_____ ZIP: _____
DATE OF BIRTH: _____ HOME#:_____ CELL#:_____
E-MAIL_____
HOW DID YOU HEAR ABOUT US? _____ OCCUPATION: _____

ARE YOU CURRENTLY TAKING ANTIDEPRESSANTS, MOOD ALTERING OR OTHER PRESCRIBED MEDICINE?_____
ARE YOU CURRENTLY UNDER A PHYSICIANS CARE? IF YES, DESCRIBE:
_____

DO YOU HAVE A WAXING APPOINTMENT TODAY? YES_____ NO _____

DO YOU HAVE A HISTORY OF THE FOLLOWING? (Circle all that apply)

Accidents	Sprains	Breast Augmentation	Decreased Range of Motion
Neck Pain	Seizures	Diabetes	Sexually Transmitted Diseases
Whiplash	Abdominal Pain	Varicose Veins	Headaches
High Blood Pressure	Disk Problems	Stroke	Mild Back Problems
Low Back Pain	Allergies to Oils	Wear Contacts	Broken Bones
Heart Condition	Arthritis, Bursitis	Surgery	Auto Immune Disorder
Have Prosthesis	Nervous Tension	Joint Aches	Cancer	Colitis

Circle yes or no to the following questions:

Do you smoke? YES NO
Do you burn easily in moderate sunlight? YES NO
Had chemical peels? YES NO
Use Retin-A? YES NO
Use the acne drug Acutane? YES NO
Have regular sleep patterns? YES NO
Are you taking oral contraception? YES NO
Experience skin breakouts? YES NO
Experience ingrown hair? YES NO
Suffer from sinus problems? YES NO
Do you have specific skin concerns? YES NO
If yes, specify"_____

Do you experience any of the following conditions on your skin? (Circle all that apply)
Flakiness Obvious dryness Redness Tightness Oiliness

Have you ever had any reactions to any of the following? (Circle all that apply)
Cosmetics Pollen Food Medicine Fragrance Iodine Sunscreens
Other: _____

Is there anything Santa Fe should be aware of before we start this procedure?
_____

PLEASE READ THE FOLLOWING AND SIGN BELOW

Reservations cancelled without prior notice will be billed at full price of each service scheduled.
I understand that this procedure is not a replacement for medical care and that no diagnosis will be made.
I am responsible for paying for any appointment cancellation of less than 24 hours.

DATE: _____
SIGNATURE: _____