CORRESPONDENCE LOG

NAME:	Numbing Issues ☐ No Pictures ☐ Ins PW ☐ Office ☐
Referred by:	Procedure: EB ☐ EY ☐ L ☐ U ☐ Bi ☐ R ☐ S ☐ C ☐ TU ☐
DATE:	Prior work ☐ Contraindication ☐

PROCEDURE LOG

Date:________Procedure: __________________Needle:________Brand:_____Color:_____________ Ratio: ________________.
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Date:________Procedure: __________________Needle:________Brand:_____Color:_____________ Ratio: ________________.
Date:________Procedure: __________________Needle:________Brand:_____Color:_____________ Ratio: ________________.

By signing below, client is happy with the services received, will follow all aftercare instructions, send pictures, and schedule online when needing a touch-up or adjustments to the work rendered today. Your happiness with the healed result is important and it could take more than one treatment to accomplish this goal.

Touch Up fees: Prices vary depending on the timeframe from your last appointment.

Client's Signature ____ Date: _____________________.

Client's Signature ____ Date: _____________________.

Client's Signature ____ Date: _____________________.

Client's Signature ____ Date: _____________________.

Client's Signature ____ Date: _____________________.

Client's Signature ____ Date: _____________________.

Client's Signature ____ Date: _____________________.

CLIENT HISTORY FORM

Print Name	Location of Service: 623 N LIME AVENUE SARASOTA, FL. 34237

Email	Birth Date	Age	Gender
Address	City	State	Zip code
Cell Phone: ( )	Emergency Contact Name and Number		

Circle either yes or no for each question. **If you answered "Yes" to any questions, use the next page to provide an explanation and reference the question number.** Also list any other medical condition you have that was not listed on this form or information you want the artist to be aware of. ***Please answer the questions accurately. The information is used to help the artist decide the proper technique and formulas for the client.***

1	YES	NO	Are you pregnant, nursing, or on fertility treatments? No tattooing allowed	**21**	YES	NO	Do you tend to faint or become dizzy? Please eat and be hydrated before coming to our appointment.
2	YES	NO	Have you had any alcohol in the last 24 hours? This will make you sensitive and bleed more	**22**	YES	NO	Do you have any seizure related conditions?
3	YES	NO	Have you had aspirins or anything that thins the blood in the last week?	**23**	YES	NO	Have you had **any** vaccines in the last month?
4	YES	NO	Are you taking any mood-altering medication or drugs? Ativan, marijuana, valium, Xanax, etc.	**24**	YES	NO	Do you intentionally tan: sun exposure ☐ tanning bed ☐ Do you currently have a sunburn? ☐
5	YES	NO	Are you taking any diet medications or changed your diet in the last two weeks?	**25**	YES	NO	Do you use tobacco or smoking products?
6	YES	NO	Do you take prescription medications? List on the next page.	**26**	YES	NO	Do you have high anxiety?
7	YES	NO	Are you undergoing radiation or chemo-therapy treatment?	**27**	YES	NO	Have you ever had permanent cosmetics or tattoos? List on the next page when and where
8	YES	NO	Have you had any surgeries on or near the area?	**28**	YES	NO	Have you had any type of a tattoo removal on the area to be treated? List on next page when and where
9	YES	NO	Have you had an antibiotic in the last two weeks?	**29**	YES	NO	Do you have difficulty numbing during dental visits or surgeries?
10	YES	NO	Do you have to pre-medicate with an antibiotic prior to dental or other invasive procedures?	**30**	YES	NO	Are you sensitive to epinephrine?
11	YES	NO	Do you have a history of any heart conditions?	**31**	YES	NO	Do you have a history of sensitivities?
12	YES	NO	Do you have a history of a stroke?	**32**	YES	NO	Are you allergic or sensitive to any metals, example: metals used for jewelry?
13	YES	NO	Do you have **high blood pressure** ☐ or **low blood pressure** ☐	**33**	YES	NO	Are you sensitive or allergic to make-up, hair dyes, or topicals?
14	YES	NO	Do you bleed excessively from minor cuts or been diagnosed as a Hemophiliac?	**34**	YES	NO	Are you allergic to: honey ☐ colloidal silver ☐
15	YES	NO	Do you have any autoimmune disorders? May need more touch ups	**35**	YES	NO	Are you sensitive to petroleum-based products or Vitamin E?
16	YES	NO	Are you diabetic? Type 1 ☐ or Type 2 ☐ Is it under control? Yes ☐ or No ☐	**36**	YES	NO	Do you tend to develop keloids? Raised/bubble type scars If yes, have you had your ears pierced? Any keloids?
17	YES	NO	Do you have a thyroid condition? May need more touch ups	**37**	YES	NO	Have you had waxing, threading, or electrolysis in the area?
18	YES	NO	Have you experienced Hepatitis or Jaundice during the past 12 months or have a liver condition?	**38**	YES	NO	Do you use oily make-up removers or moisturizers on the area?
19	YES	NO	Are you anemic or being treated for anemia? Iron deficiencies heal very light and need more touch ups.	**39**	YES	NO	Do you use growth serums or castor oil on lashes or eyebrows?
20	YES	NO	Do you have a history of MRSA or slow healing conditions? List on the next page	**40**	YES	NO	Do you get fever blisters on your lips?

Please circle any of the following which may pertain to you and explain on the next page:

Trichotillomania	Eye Surgeries	Botox/Fillers
Vitiligo	Use Contacts	Eyelid/Facial Surgeries
Eczema	Dry/Watery Eyes	Accutane Usage (past or present)
Dermatitis	Ocular or Oral Herpes	Oily Skin
Hyper/Hypopigmentation	Tear Duct Plugs	Glycolic, Retin-A, Exfoliating Products
Keloids	Skin Cancer	Other:

The artist makes no attempt or claim to practice medicine or diagnosis any conditions. Consult with a doctor if you are unsure if proceeding is in your best interest. By signing below, you attest that all answers are true and accurate to the best of your knowledge, and you assume all responsibilities for proceeding with any known or unknown conditions.

Client's Signature: _____ **Date**_____

MEDICAL LOG

Question #	Date	Explanation

RETURNING APPOINTMENT

I, _____ agree that all paperwork filled out on _____ is accurate and applies to today's appointment. Please tell the artist and adjust the "medical log" above if anything has changed since your last appointment.

Client's Signature _____ Date: _____.

Client's Signature _____ Date: _____.

Client's Signature _____ Date: _____.

Client's Signature _____ Date: _____.

Client's Signature _____ Date: _____.

Client's Signature _____ Date: _____.

Client's Signature _____ Date: _____.

Cosmetic Tattoo Consent Form

Please carefully read and initial to acknowledge and agree to each statement.

_____*(Int.)* I am not pregnant, nursing, menstruating, or receiving fertility treatments.

_____*(Int.)* I am not impaired and can make choices that are not influenced by alcohol and/or illegal drugs.

_____*(Int.)* I understand the process, risks, and complications that may occur during and after the procedure.

_____*(Int.)* I understand the artist is not a medical professional and cannot predict a reaction to the products and techniques used and is not liable for any side effects the day of the procedure or in the future.

_____*(Int.))* I understand not following the aftercare may ruin the results and/or cause an infection.

_____*(Int.))* I do not have a medical or skin condition(s) such as but not limited to: infection, a rash anywhere on the face or body, acne, scarring (Keloids), eczema, psoriasis, freckles, moles, signs of cancer, biopsy, sunburn, or currently going through radiation and/or cancer treatments.

_____*(Int.)* I understand, in the event a MRI (Magnifying Resonance Imaging) procedure is prescribed, I should advise my physician and radiologist that I have permanent cosmetics (a tattoo).

_____*(Int.)* I authorize the technician to obtain pre-procedural and post-procedural pictures and give permission to use such pictures for publication and/or teaching purposes.

_____*(Int.)* I understand and fully accept the procedure(s) will result in a permanent change to my appearance.

_____*(Int.)* I understand cosmetic tattooing is an art form and NOT an exact science and I realize that my body and skin are unique. The technician cannot predict how my skin may react to the procedure or how it may or may not accept color. Some skin types will not accept or heal pigment in a consistent manner.

_____*(Int.)* I accept that the technician cannot predict how many visits it will take to complete my procedure. A touch up or perfecting session may be necessary for an additional fee(s).

_____*(Initial)* I understand the healing process will go through several changes and could take many weeks before the true results appear. The actual healed color will be modified slightly due to my own unique skin's acceptance of the pigments and my skin undertones.

_____*(Int.)* I understand the appearance of the tattoo will fade and change over time due to natural factors. The artist and/or business is not responsible for the longevity or appearance overtime.

_____*(Int.)* I understand doing certain activities may alter and/or degrade my cosmetic tattoo(s) resulting in the inability of my skin to allow future tattoos in the affected area. This will include but not be limited to: extreme sun exposure, chemical peels, skin exfoliators, laser treatments, LED Therapy, cosmetic/medical surgeries, implants, injections, and other skin altering treatments, etc.

_____*(Int.)* I have received no unrealistic warranties/guarantees or promises with respect to the benefits to be realized from or the consequences of any procedure(s) received.

_____*(Int.)* I acknowledge it is not reasonably possible for the technician to determine whether I might have an allergic reaction to the pigments or processes used for my tattoo. A skin test is offered upon REQUEST for a $25.00 charge. The test will be done by the artist, not a medical professional. A nonreactive skin test does not preclude an allergic reaction occurring at a future point in time. When determining an allergic reaction, please seek advice from a true allergy specialist.

I **decline** the skin test___ (int) OR I **request** a skin test___ (int)

Initial only if it applies to you. All others, write N/A

_____*(Int.)* I am following my doctor's orders to premedicate with an antibiotic similar to dental or invasive procedures.

_____*(Int.)* I accept all responsibilities for NOT taking an antibiotic even if my doctor suggests doing so for invasive procedures.

_____*(Int.)* I am taking an antiviral medication before and during the lip procedure.

_____*(Int.)* I am **NOT** taking an antiviral medication and accept all responsibilities for this decision.

_____*(Int.)* I stopped using lash growth serums and/or oily make-up removers on the area to be tattooed per my artist's recommendation.

By signing below, I have read and understand the contents of each paragraph. I understand my signature will represent consent for today and any future services and shall remain in effect anytime work is being performed by the artist. It is my responsibility to inform of any changes that have occurred since signing this document. I understand and accept all risks involved, therefore releasing and forever discharging Michelle Brantley and any businesses or locations where procedures are done by said artist from all legal liability or liabilities both personally and professionally.

Client's Signature:_____ Date: / / .

Artist's Signature:_____ Date: / / .

MICHELLE BRANTLEY