

CLIENT HISTORY FORM

Print Name	Location of Service:		
Email _____ @ _____	Birth Date	Age	Gender Female / Male
Address	City		State
Emergency Contact Name and Number	Home Phone () ()		Cell Phone () ()

Today's Procedure Description: **Eyebrows** **Upper & Lower Eyeliner** **Upper OR Lower Eyeliner** **Eye Shadow**
 Lip Liner **Full Lips** **Micro Needling** **Unilateral Areola** **Bilateral Areolas**

Please circle either yes or no for each question listed below. *Explain any "yes" answers on the next page*

1	YES	NO	Are you pregnant or nursing? No tattooing allowed	27	YES	NO	Do you have dry eyes?
2	YES	NO	Do you menstruate? Not 3 days prior to tattooing If yes: Next cycle date _____	28	YES	NO	Do you wear contact lenses?
3	YES	NO	Have you had any alcohol in the last 24 hours? Makes you sensitive and bleed more	29	YES	NO	Do you have glaucoma or any other eye disease?
4	YES	NO	Do you use tobacco? Smokers tend to heal slower. This will affect the timing for touchup appointment, if applicable.	30	YES	NO	Do you have prosthetic implants? List on the next paper
5	YES	NO	Have you ever had permanent cosmetics or tattoos? List on the next page when and where	31	YES	NO	Do you have a tendency to faint or become dizzy?
6	YES	NO	For previous permanent cosmetics or tattoos, did you have any problems with healing after they were applied? List on next page	32	YES	NO	Do you have arthritis?
7	YES	NO	Have you had any type of a tattoo removal? List on next page	33	YES	NO	Do you have a thyroid condition? May need more touch ups
8	YES	NO	Do you have Botox or Fillers? List on the next page when and where. For eyebrows, regular botox users must wait 1 month before tattooing. Others must wait until it wears off.	34	YES	NO	Are you anemic? Iron deficiencies heal very light and need more touch ups.
9	YES	NO	Have you had a laser or chemical peel within the last 6 months?	35	YES	NO	Do you take prescription drugs? List on the next page.
10	YES	NO	Is your skin oily? May need more touch ups	36	YES	NO	Are you under treatment for depression?
11	YES	NO	Do you routinely use Retin-A, glycolic, or other exfoliating products?	37	YES	NO	Are you now, or have you ever been on the acne treatment Accutane? Must wait at least one year before having tattoos
12	YES	NO	Do you intentionally tan – Direct sun or tanning bed?	38	YES	NO	Do you have any type of herpes? Cold sores or fever blisters. Will need to take medication before any treatments on or near the lips
13	YES	NO	Do you scar easily from minor skin injuries?	39	YES	NO	Do you have any problems healing? List on the next page
14	YES	NO	Do you hypo-pigment? (Lack of pigment on the skin)?	40	YES	NO	Do you have any medical condition that has resulted in a medical professional requiring you to pre-medicate with an antibiotic prior to a dental or other invasive procedures?
15	YES	NO	Do you develop dark spots on the skin from wounds or sun (Hyper-pigmentation)?	41	YES	NO	Do you have any seizure related conditions?
16	YES	NO	Do you tend to develop keloids or hypertrophy scars? Raised/bubbles scars	42	YES	NO	Do you personally have any history of cancer? List on the next page
17	YES	NO	Do you have any allergies to latex?	43	YES	NO	Are you undergoing radiation or chemo-therapy treatment?
18	YES	NO	Are you sensitive or allergic to hand creams or body lotions?	44	YES	NO	Have you had any surgeries in the past year? Elective and non elective. List when & where on the next page
19	YES	NO	Are you allergic or sensitive to any metals, example: metals used for jewelry?	45	YES	NO	Do you have high or low blood pressure? May need more touch ups
20	YES	NO	Do you have allergies to makeup?	46	YES	NO	Do you have a history of stroke or heart attack?
21	YES	NO	Are you allergic to hair dyes?	47	YES	NO	Do you have any heart conditions?
22	YES	NO	Do you have a history of skin sensitivities?	48	YES	NO	Are you wearing a pacemaker?
23	YES	NO	To your knowledge are you allergic or resistant to over the counter level numbing products such as ELA-Max (Lidocaine)?	49	YES	NO	Do you consume aspirin daily? When was the last time you took it?
24	YES	NO	Are you sensitive to petroleum based products or Vitamin E?	50	YES	NO	Are you diabetic? If so, Type 1 or Type 2? May need more touch ups
25	YES	NO	Have you had an antibiotic in the last two weeks? Must wait two weeks or longer before having a tattoo	51	YES	NO	Do you have any autoimmune disorders? May need more touch ups
26	YES	NO	Have you experienced Hepatitis or Jaundice during the past 12 months?	52	YES	NO	Do you bleed excessively from minor cuts or been diagnosed as a Hemophiliac?

If you answered "Yes" to any questions above, use the next page to provide an explanation and the number of the specific question. A "yes" answer is valuable to me as your technician as each person's body is unique, or it may indicate that based on any health conditions that affect healing, it would be advisable or required for you to consult with your physician before proceeding. Please list on the next page any other medical condition you have that were not listed on this form.

Client's Signature _____ Date _____

Cosmetic Tattoo Consent Form

The nature and method of the proposed cosmetic tattoo procedure(s) has been explained to me by Michelle Brantley, including the usual risks inherent in the procedure process and the possibility of complications during and following the procedure(s). I understand there may be a certain amount of discomfort or pain associated with the procedure(s) and that other adverse side effects may include minor and temporary bleeding, bruising, swelling, and/or redness or other discolorations. Due to swelling, unevenness may occur in the design. Secondary infection in the area of the procedure may occur, however, adherence to the written after care instruction given by Michelle Brantley will help minimize the occurrence. Fading or loss of pigment may occur. You may need multiple touch ups depending on how you heal. _____(Initial)

***I am not pregnant. _____(Initial)**

*** I am not under the influence of alcohol and/or drugs. _____(Initial)**

*** I acknowledge that complications as a result of a cosmetic tattoo procedure (s) may include infection, particularly in the event my post-procedural instructions are not followed. _____(Initial)**

*** I do not have medical or skin conditions such as, but not limited to: acne, scarring (Keloids), eczema, psoriasis, freckles, moles, or sunburn in the area to be tattooed that may interfere with said tattoo. I do not have an infection or a visible rash anywhere on my body, I have advised my technician. _____(Initial)**

***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 in my tattoo, and I agree to accept the risk by waiving a patch test and understand that such a reaction is possible. If I want a patch test I understand it will take 24hours to determine my eligibility for said tattooing and I must inform the technician before signing this agreement.. _____(Initial only if waiving a test patch)**

***It has been explained to me, immediately after the procedure(s) is completed, the color will appear darker and bolder. It has also been explained to me that within a short period of time (usually 5-7 days) during the healing process, the color will lighten/soften and the design will heal softer than it looked the day it was performed (Please do not pick any scabs and be aware pigment can stain clothing and sheets). _____(Initial)**

***I acknowledge that hyper-pigmentation (darkening of the skin) or hypo-pigmentation (absence of color in the skin), or scarring is a possibility as a result of my body's reaction to the skin being broken during the procedure. I realize that my body is unique and that the technician cannot predict how my body will react as a result of this procedure. _____(Initial)**

***I acknowledge that the procedure(s) 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 results. Tattoo removal is a surgical procedure which may cause scarring and/or disfigurement. _____(Initial)**

***I understand that future laser treatments, plastic surgery, implants, injections, and other skin altering procedures ay alter and degrade my cosmetic tattoo procedure(s). I further understand that such changes are **NOT** the responsibility of the technician, and such changes in my appearance may **NOT** be correctable through further cosmetic tattoo procedures. _____(Initial)**

***I understand that tattoos may cause MRI (Magnetic Response Imaging) artifacts and that there may be a warming and/or tingling sensation in the tattooed area during the MRI due to the iron oxide properties of some pigments. It is understood that I should advise my physician that I do have permanent cosmetics (a tattoo) in the event a MRI procedure is prescribed. _____(Initial)**

***I authorize the technician to obtain pre-procedural and post-procedural pictures, and give her permission to use such pictures for publication and/or teaching purposes, as she chooses. _____(Initial)**

*** I acknowledge the receipt of written instructions advising me of the proper care of my procedure(s),and ointment by the technician. I understand the absolute necessity for following these instructions. _____(Initial)**

*** I understand that cosmetic tattooing is an art form and NOT an exact science, and I acknowledge that NO guarantees have been made to me as to the result of this procedure.** Some skin types will not accept or heal pigment in a consistent manner...your skin and how well you take care of your cosmetic tattoo(s) will determine your result. I realize that my body and my skin are unique and that the technician cannot in any way predict how your skin may react to the procedure or how it may or may not accept color. A touch up is recommended and encouraged. I also realize that the technician cannot predict how many visits it will take to complete my procedure. _____(Initial)

* I accept full responsibility for determining the color, shape and position of the pigments that will be applied. I understand the actual healed color of the pigment applied will be modified slightly due to my own unique skin undertones. _____(Initial)

* This contract is to remain in effect from the date signed by the client and its contents are to still apply whenever work is being performed on myself by the technician. It is my responsibility to inform the technician if any changes have occurred in my medical history. _____(Initial)

* I have read and understand the contents of each paragraph above. I have received no unrealistic warranties or guarantees with respect to the benefits to be realized from, or consequences of the aforementioned procedure(s). _____(Initial)

I, (print name) _____, acknowledge by signing this consent form, have been given the full opportunity to ask the technician any and all questions about cosmetic tattooing procedure(s), it's process, and the risks involved from the technician. The decision to have cosmetic tattooing procedure(s) performed is my own and I understand and accept all risks involved, therefore releasing Michelle Brantley of any and all legal liability. In consideration of her tattooing me, I hereby release and forever discharge her and her employees both personally and under the business name of *SeaChelle's Permanent Makeup* from all claims, demands, actions and causes of actions arising out of said treatment procedures which I, my heirs, executors, administrators, or assigns may have stemming from my decision to have either a Permanent Makeup procedure and/or an Areola/Nipple procedure. I agree that this waiver also pertains to and is designed to protect any and all establishments where Michelle Brantley does business. The technician is a trained, experienced, and skilled artist who makes no claims to be anything more. Permanent makeup/cosmetic tattooing is not a medical procedure, but is an art form: *the art of tattooing*. Any and all fees are to be paid prior to or on the day of the procedure and are nonrefundable.

In regards to the *Areola/Nipple Tattooing*, I _____, am responsible for the total payment. In addition, I understand that the technician, Michelle Brantley will not bill my insurance company for any procedures. Also, I was made aware that Michelle Brantley only does self-pay cosmetic procedures. However, if I bill my insurance company, any money (s) paid toward the procedure will be forwarded to me. I also understand that I will not be reimbursed by Michelle Brantley the difference between the insurance allowable amount and the total amount paid to Michelle Brantley.

Client's Signature: _____ Date: _____.

Technician's Signature: _____ Date: _____.

Michelle Brantley

Signature of parent or legal guardian if client is under 18 years of age:

_____ Date: _____.

Procedure Log

Procedure(s): _____ Date: _____

Anesthetics Used: _____

Method Used: **Rotary Pen** **Coil** **Manual** Needles: _____ . Needles: _____ .

Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____
Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____
Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____
Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____
Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____
Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____
Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____

By signing below, client agrees that he/she is happy with the services rendered by Michelle Brantley. In addition, the client will follow all aftercare instructions provided and contact Michelle Brantley if he/she needs a touch-up or adjustments to the work rendered today. Your happiness with the end result is important and may take more than one treatment to accomplish this goal. Touch Up fees: up to 6 months \$75.00 (Prices changes after 6 months)

Client's Signature: _____ Date: _____

Touch-Up Appointment Agreement

I, _____ agree that all paperwork filled out on _____ is accurate and applies to today's appointment. Please write below anything that has changed since your last appointment.

Client's Signature _____ Date: _____

Procedure Log

Procedure(s): _____ Date: _____

Anesthetics Used: _____

Method Used: **Rotary Pen** **Coil** **Manual** Needles: _____ . Needles: _____ .

Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____
Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____
Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____
Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____
Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____
Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____
Ink Brand: _____	Ink Color: _____	Ratio: _____	_____	_____	_____

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Client's Signature: _____ Date: _____

Precautionary *Corona Virus, Covid-19*, Liability Release Form

Due to the 2019-2020 outbreak of the *Novel Corona Virus/COVID-19*, the specialists at SeaChelle's, LLC. has improved and expanded the sanitation protocols to fight the spread of COVID-19 and other communicable conditions suggested by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health (FDOH) guidelines.

The specialists at SeaChelle's, LLC. will abide by the same standards mentioned in this release form.

Please reschedule if you have any symptoms or have been exposed to someone with symptoms or who has been diagnosed with the Covid-19 Virus.

Symptoms of COVID-19 include but not limited to:

- Fever
- Fatigue
- Cough
- Difficulty breathing

_____ I affirm and attest that I, as well as all household members, **do not currently have, nor have experienced the symptoms listed above within the last 14 days.**

_____ I affirm and attest that I, as well as all household members, **have not been diagnosed with COVID-19 within the last 30 days.**

_____ I affirm and attest that I, as well as all household members, **have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.**

_____ I affirm and attest that I, as well as all household members, **have not traveled outside of the country, or to any city outside of our own that is or has been considered a "hot spot" for COVID-19 infections within the last 30 days.**

_____ I understand that **the specialists at SeaChelle's, LLC. are not liable for any exposure to the virus or any other contagion during my visit.**

_____ I affirm and attest that **my procedure is elective and in no way is necessary. I chose to make the appointment and to enter at my own risk.**

_____ I affirm and attest that I, follow the most current Centers for Disease Control and Prevention (CDC) and Florida Department of Health (FDOH) guidelines imposed by the state of Florida.

www.cdc.gov/coronavirus

<https://floridahealthcovid19.gov/>

By signing below I agree to the above statements and will not hold SeaChelle's, LLC or the specialist liable for any possible exposure or harm due to COVID-19.

Signature: _____ Date: _____