Client Information Sheet

Please Print

Name:__________ Date of Birth:__________ Age:__________

Profession:__________

Mobile Number:__________ Do you receive/send text messages? ❑ Yes ❑ No

Additional Phone Number:__________

Email Address:__________

Street Address:__________

City:__________ Zip Code:__________

Mailing Address:__________

City:__________ Zip Code:__________

Emergency Contact: Name:__________ Phone Number:__________

Relationship to you:__________

Primary Care Doctor's Name:__________ Phone Number:__________

Who referred you?__________

PROCEDURES DESIRED:

❑ Eyeliner ❑ Eyebrows ❑ Lipline* ❑ Full Lip Color* ❑ Nipples

❑ Micro-Needling ❑ Beauty Mark ❑ Other:__________

*Lip Procedures: Have you ever has a herpes or cold sore? ❑ Yes ❑ No
Please contact your physician for a prescription of ZOVIRAX or some other anti-viral medication. It is mandatory to take this medication if you desire a lip procedure.

Signed:__________ (Client)

Are you currently under the care of a physician other than for primary care? ❑ Yes ❑ No

Do you take antibiotics when you go to the dentist? ❑ Yes ❑ No

Do you suffer from: ❑ Allergies ❑ Moles or Freckles at site of tattoo ❑ Hepatitis ❑ Heart Problems ❑ Hemophilia ❑ Diabetes ❑ Skin Problems ❑ Scarring (Keloids) ❑ Eye Problems ❑ Epilepsy

❑ Other–please explain:__________

Are you presently taking any medication or vitamins which thins the blood? ❑ Yes ❑ No

Are you taking other medications including anti-depression or mood altering drugs? ❑ Yes ❑ No
If yes, please explain:__________

Are your pregnant or nursing? ❑ Yes ❑ No

Do you wear contact lenses? ❑ Yes ❑ No
If yes, please bring glasses to your eyeliner appointment as you cannot put in contact lenses directly after the eyeliner procedure.

The above is complete and accurate as to my medical history.

Signed:__________ (Client) Date:__________