KW Kosmetics

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Permanent Makeup Intake Form

Name: _____ Birthday: _____

Address: _____

City: _____ State:_____ Zip:_____

Phone #: _____ Email: _____

Emergency Contact/Phone #: _____

Please Circle your answer:

Would you like to be added to our email list for information and discounts? YES NO

Medical and Cosmetic History

Are you currently taking any medications or vitamins? YES NO

If yes, Please list:

_____

Do you have any allergies? YES NO

If yes, please explain:

_____

Have you ever had permanent makeup or any other cosmetic tattoo procedures? YES NO

If yes, when?:

_____

Do you currently have any blemishes, cuts, irritation, or infections on your face? YES NO

If yes, please explain:

_____

Do you have any moles, raised areas, prior or current piercings in the projected procedural area? YES NO

If yes, please list:

_____

Have you had any recent medical procedures? YES NO

If yes, please explain:

_____

Do you have any chronic medical conditions? YES NO

If yes, please explain:

_____

Are you pregnant or breastfeeding? YES NO

Do you have lupus? YES NO

Do you have diabetes? YES NO

Do you have a vascular or cardiovascular condition? YES NO

Do you have Eczema, Psoriasis around the eyes, or have you had a recent eye surgery? YES NO

Have you received Botox injections in the last 30 Days? YES NO

If so, when?: _____

Do you have any skin conditions? YES NO

If so, please list:

_____

What is your skin type? (Please circle your skin type):

Dry Normal Combination Oily

Do you use skincare products with Retin- A, Retinols, or Vitamin A? YES NO

Have you used Accutane or been treated for acne in the last year? YES NO

Are you on any blood-thinning medications, like Aspirin? YES NO

Have you had any facial procedures done in the last 30 days? YES NO

Do you have Hemophilia or other blood disorders? YES NO

Do you have a transmittable blood disease, such as hepatitis or HIV? YES NO

Have you ever been diagnosed with cancer? YES NO

When was your last treatment?:

_____

Have you had MRSA in the last 6 months? YES NO

Are you currently wearing contact lenses? YES NO

Have you sunbathed or used a tanning bed in the last two weeks? YES NO

Are you currently ill? YES NO

Please list any other conditions, diseases, or disorders not listed above?

_____

_____

What would you like to correct or enhance about your appearance with permanent makeup?

_____

_____

If you have done cosmetic tattoos in the past, did you experience any adverse side effects or concerns with final results?

_____

_____

What products do you use on and around the projected area (including but not limited to moisturizer, mascara, lash serum, makeup)?

_____

_____

With my signature below, I confirm that I have accurately completed the above information to the best of my knowledge. I agree to notify the provider of any other relevant information that may affect my procedure, including any changes to the information above. I agree to communicate with my provider about any pain or discomfort experienced during or after the procedure. I release my provider of any and all liability of injury or damages that may arise because I have not represented my medical history accurately.

Printed Client's Name: _____

Signature: _____ Date:_____

Provider's Name: _____

Signature: _____ Date: _____

Permanent Makeup Consent Form

Please Initial Each Statement:

_____ I confirm I am at least 18 years of age.

_____ I have elected, by my own decision, to have a permanent makeup procedure performed.

_____ The procedure, including the process and objective, had been explained to me before undergoing the permanent makeup procedure.

_____ I have been given the opportunity to ask questions regarding any benefits, risks, or possible complications of the procedure.

_____ I understand and acknowledge any risks or complications associated with the procedure as they've been explained to me.

_____ I understand that permanent makeup may result in adverse changes to permanent cosmetics, such as plastic surgery or hair removal.

_____ I understand that the projected results and final results may not be exact and results may vary.

_____ I understand that I may need touch-ups to obtain and maintain my desired results.

_____ I understand that results may vary depending on individual factors, such as oily skin, sun exposure, or response to pigmentation.

_____ I understand this is an elective cosmetics treatment and is not medically necessary.

_____ I understand that permanent makeup is not recommended if I am breastfeeding or pregnant.

_____ I understand that some of the following conditions that may prevent me from receiving permanent makeup treatments are but not limited to: certain cardiovascular conditions, cancer, epilepsy, diabetes, blood diseases, or present illness.

_____ I have followed all pre-procedure care instructions as they have been explained to me.

_____ I understand all aftercare procedures for permanent makeup as they have been explained, and I understand the importance of adhering to the instructions given to me.

_____ I confirm that I have given an accurate account of my medical history, including any allergies or medications that I am currently taking or intend to take.

_____ I understand that a skin test of the pigment is offered upon request, and the test result is not viewed by a medical professional. A non-reactive skin test does not preclude an allergic reaction occurring at a future point in time.

_____ I understand a non refundable/ non transferable deposit was required at the time of booking and there will be no refunds.

_____ I understand that there will be no refunds on rendered services.

_____ I understand any services performed with an undisclosed existing condition(s) that would deem you an unsuitable candidate for permanent cosmetics are performed at your own risk.

With my signature below, I attest that I have read and fully understand this consent form and all details from above. By signing below, I assume all and full responsibilities for any risks or injuries, losses, side effects, or damages, that may occur as part of the procedure. I will not hold my provider (signature below) responsible for any conditions present at the time of the treatment but not disclosed that may affect the treatment. I do not hold my provider responsible for any effects that may incur as a result of not following proper aftercare instructions.

Printed Client's Name: _____

Signature: _____ Date:_____

Provider's Name: _____

Signature: _____ Date: _____