Beauty By Design, LLC

Today's Date _____/_____/_____

Name _____ Date of Birth _____/_____/_____ Email: _____

Ethnic Background, please include all nationalities _____

Address _____Apt. # _____City:_____

State _____ Zip _____ Home Phone (_____)_____ Cell (____)_____

Occupation: _____ If we call you at home, do you want confidentiality? ☐ No ☐ Yes

May we call you at work? ☐ No ☐ Yes If Yes, my work number is(_____)_____

Emergency Contact, Name _____ Phone(_____)_____Relationship_____

Who may we thank for referring you? _____

Procedure(s) desired: ☐ Brows ☐ Eyeliner ☐ Lips ☐ Camouflage ☐ Areola Complex ☐ Correction

List all medications you are presently taking

Name of drug	Mg. or mcg.	How many ea. day	Why it was prescribed to you

List all medications you took in the last six months that you are no longer taking:

Name of drug	Mg. or mcg.	How many ea. day	Why it was prescribed to you

Practitioner Signature _____ **Date** _____/_____/_____

GENERAL MEDICAL Client Name: _____

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Do you have? (check all that apply)

- **Fever Blisters/Cold Sores (Ever, even one time)**
- Glaucoma or other eye disease/disorder
- Grave's Disease
- Heart Disease
- Mitral Valve Prolapse
- Valve Implants
- Pacemaker
- Stents
- Diabetes requiring insulin
- Problems with healing
- Keloids
- Seizures
- Dermatological Disorder
  If so, what? _____
  Active or in Flare-ups? _____
- Hemophilia or Clotting Disorder
- Autoimmune Disorder
- Pre-existing nerve damage
- Tattoos
  Colors you are sun sensitive to: _____

  _____
- Trichotillomania (pulling of hair, brows, lashes)
- Alopecia Totalis or Areata
- Allergies
  List: _____

Are you? (check all that apply)

- Pregnant
- Planning cosmetic surgery
  If so, what & when? _____
- Currently under the care of a physician
  Describe _____

Do you practice outdoor activities? Circle all that apply

Tennis	Swimming
Golf	Skiing
Gardening	Walking
Boating	Other

Have you had? (check all that apply)

- **Fever Blisters/Cold Sores (Ever, even one time)**
- Eye Infections (Are you prone to them)
- Vision Correction Procedure (Lasik, RK) within the past 3 months
- Heart Attack - When? _____
- Joint Replacement, Organ Transplant
- Eye Trauma
- Seizures
- Fainting Spells
- Hepatitis - What Type: _____
- Hepatitis Test - When? _____
- Fat Transfer Injections - If yes, where? _____
- Gore-Tex Implants - If yes, where? _____
- Aesthetic or Cosmetic Procedures
  If yes, where? _____
- Laser Treatments
- What type & why? _____

Do you use? (check all that apply)

- Accutane (currently or within the past year)
- Antibiotics prior to dental procedures
- Steroids
- Retin-A, Glycolic Acid, Vitamin C or other Exfoliants
- Tanning Beds
- Eyebrow Tinting
- Eyelash Tinting
- Latisse
- Botox When_____
- Chemical Peels When_____
- Chemotherapy or Prophylactic dose of Chemotherapy
- Blood Thinners

Physician's Name:_____
Address: _____
Phone: _____
Specialty: _____

Signature of Practitioner _____ Date ____/____/_____
Client Name_____ Date ____/____/_____

INFORMED CONSENT TO PROCEDURE

Initial:

1. I absolutely understand and accept that such procedure is a process, often requiring multiple applications of color to achieve desirable results and the 100% success cannot be guaranteed. _____

2. Depending on the procedure(s), which I select, I accept responsibility for determining the shape, and position of eyebrows, eyeliners, lipliner and/or full lip color. _____

3. I understand that the color selection and color results in all procedures are not an exact science. _____

4. I understand that positioning of my procedures can be affected if I have elected or wish to elect cosmetic surgery, Botox or Restalyne and I assume this responsibility. . _____

5. I am aware that if I am to receive an MRI after the procedure, I must tell the Radiologist that I have iron oxide permanent cosmetics. _____

6. If I am a lens wearer, I realize that I must keep my lenses out the day of an eyeliner procedure. _____

7. I understand that this procedure will fade and this fading can alter the original pigment color and that this determines that it is a time for a touch-up visit. _____

8. I realize this is an elective cosmetic procedure and is not medically necessary. _____

9. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment. _____

10. I understand that many lasers & IPL's (Intense Pulse Lights) including those used for hair removal, anti-aging, Photo Facials, removal of lines may or will turn permanent make up dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent make up. _____

11. I give my consent to Yvonne R. Battistelli to confer with my physicians for medical information required for the safety of my procedures. _____

12. I agree to accompany my practitioner to the emergency room in the event they were to be accidentally stuck with my needle and take a blood test for their safety & disclose all test results to my practitioner. _____

13. I am aware that if an infection occurs after I have received Permanent Cosmetics to see with my primary physician or an emergency room, ***immediately***. _____

14. If I had permanent cosmetics performed previously by another practitioner, I do not hold Yvonne R. Battistelli responsible for future allergic reactions or contraindications. _____

ACCEPTANCE:

I have read and understand these risks listed above and they have been explained to me. **I DID NOT JUST SIMPLY SIGN THIS DOCUMENT WITHOUT READING IT.** I certify that the information in the above questionnaire is accurate and my questions have been answered. I accept full responsibility for any complications that may arise or result during or following the cosmetic procedure(s) to be performed at my request.

Signature of Client X_____ **Date** _____/_____/_____

Signature of Practitioner _____**Date** _____/____/_____