LASTING LOOKS
OF SARASOTA
nutritional skin care and permanent make-up
Nurture and Nourish the way Nature intended

Confidential Medical Profile

Date_____

Name_____ D.O.B._____ Age_____

Address_____
Street City State Zip Code

Daytime Phone_____ Home Phone_____ Email Address_____
Area Code Area Code

Referred By _____ Practioner Use_____

Location _____ Description_____

To avoid unforeseen complications, please answer the following questions:

□Yes □No Are you under the age of 18? Legal guardians initials:
□Yes □No Have you had any aspirin or blood thinning products within the last 7 days?
□Yes □No Any mood altering drugs within the last 8 hours?
□Yes □No Do you have any history of cold sores, herpes, or fever blisters?
□Yes □No Are you sensitive to Latex?
□Yes □No Have you had a chemical or laser peel? If so, when? _____
□Yes □No Do you have problems with healing?
□Yes □No Previous problems with tattoos or has your physician advised you not to have a tattoo at this time?
□Yes □No Are you currently undergoing radiation or chemotherapy?
□Yes □No Are you currently using Retin-A or "Alpha Hydroxy" skin care products?
□Yes □No Do you wear contact lenses?
(if yes, I understand they must be removed during my eyeliner procedure and should not be replaced until the next day.)
□Yes □No Are you allergic to any metal? *(e.g. you can only wear 14K gold)*
□Yes □No Have you ever had any permanent make-up procedures before?
□Yes □No Medication, including immunosuppressive, such as anti-inflammatory or steroids?
□Yes □No Withdrawal from caffeine products?
□Yes □No Are you allergic to topical antibiotic preparations or desensitizers?
(e.g. Polysporin, Bacitracin, Neosporin, or "Caine" family of drugs or Petroleum)
□Yes □No Is there any history of skin diseases or remarkable skin sensitivities?
□Yes □No Are you presently taking Vitamins A and/or E in any form?
□Yes □No Are you pregnant or nursing?
□Yes □No Are you required to take antibiotics during dental or invasive medical procedures?

Please check any of the following which pertain to you:

Heart conditions
Allergies to makeup
Accutane treatment
Dry eyes
Keloid or hypertrophy scars
Diabetes
Stroke
Chest pains
Shortness of breath
Alopecia
Epilepsy/seizures of any kind
Autoimmune disorders
Refractive Eye Surgery
Glaucoma
Trichotillomania
Cancer (any type)_____

Hepatitis/jaundice/HIV
Kidney disease
Tendency to develop fever blisters on the lip
Tendency to bleed excessively from minor injuries
Keloid Formation
Hyper-pigmentation (darkening of the skin)
Hypo-pigmentation (lightening of the skin)
Diabetes
Ocular herpes

Please explain any checked question and list any other medical conditions & LIST ALL YOUR MEDICATIONS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

DOCTOR'S NAME: PHONE:

Practitioner makes no attempt to, or claim to, practice medicine. Some individuals will have complications related to permanent makeup application. These complications are usually mild and last only a few days. However, extreme complications are always a possibility. If you are healthy and there are no visible reasons restricting you from receiving a tattoo, you must approve of the design and color before the application of your permanent make-up.

_____ _____
Client Signature Date

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Informed Consent

The nature and method of the proposed Permanent Make-up (tattoo) procedure has been explained to me as having the usual risks inherent in the procedure and the possibility of complications during and following its performance. I understand there may be a certain amount of discomfort or pain associated with the procedure and that other adverse side effects may include minor and temporary bleeding, bruising, redness or other discoloration and swelling, fever blisters may occur on the lips following lip procedures in individuals prone to this problem. Fading or loss of pigment may occur. Secondary infection in the area of the procedure may occur, however, if properly cared for, is rare.

I,_____, acknowledge by signing below, that I have been given the full opportunity to ask any and all questions which I might have about the obtaining of any permanent cosmetic procedures from _____ and/or any associates. I also acknowledge that all of my questions have been answered to my full and total satisfaction. I specifically acknowledge that I have been advised of the fact and matters set below, and I agree as follows:

- I acknowledge that it is not reasonably possible to determine whether I might have an allergic reaction to any of the pigments, dyes, topical preparations, or processes used in the procedure; and I agree to accept the risk that such a reaction is possible. I have informed the practitioner of any existing problems. _____ (initial)
- I acknowledge that complications are always possible as a result of the permanent make-up procedure, particularly in the event that post-procedural instructions are not followed._____ (initial)
- I realize that my body is unique and the practitioner or any of the practitioners associates cannot predict how my skin may react as a result of the procedure. _____ (initial)
- I acknowledge that the procedure 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 result._____ (initial)
- I understand that future laser treatments or other skin altering procedures, such as plastic surgery, implants, and/or injections may alter and degrade my permanent make-up. I further understand that such changes are not the fault of the practitioner and/or any of the practitioners associates. I further understand that such changes in my appearance may not be correctable through further Permanent Make-up procedures._____ (initial)
- For the purposes of education or assistance, I consent to the admittance of authorized observers to the procedure(s). _____ (initial)
- I acknowledge that the obtaining of Permanent Make-up procedure(s) is by my choice alone, and I consent to the application of the procedure and to its attendant risks, and to any actions or conduct of the practitioner and/or any of the practitioners associates reasonably necessary to perform the procedure(s). _____ (initial)

I have read and understand the contents of each paragraph above. I acknowledge this is a contract and that I have received no warranties or guarantees with respect to the benefits to be realized from, or consequences of, the aforementioned procedure(s). I further acknowledge that at the time of signing this consent to his procedure(s), I was of sound mind and capable of making independent decisions for myself.

_____
Clients signature Date

_____
If under 18 signature of parent or legal guardian Date

I have personally reviewed the above information with my client or the client's representative.

_____
Witness signature Practitioners signature Date

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Consent Form
For Permanent Cosmetics

I hereby request and consent to the application of permanent color and consent to have the following procedures performed by _____.

Please check any of the following which pertain to you:
Eyeliner Eyebrows Lip liner Full Lip Color Scar Camouflage
Beauty Mark Areola Repigmentation Other _____

Please read and initial the following statements:

- I understand that the process used to apply color is not a one-step process and requires subsequent visits to achieve desired results. I further understand that the fee includes my first visit and ONE perfecting visit. Maintenance touch-ups are scheduled as needed and may vary from six months to three years. Fees for maintenance visits, pigment replacements, and scar camouflage are based on an hourly fee._____ (initial)
- I understand that with time pigment can and will fade and change color according to metabolism, skin type, medications, age, smoking, alcohol, sun exposure, Retin-A and Glycolic acids._____ (initial)
- I acknowledge that no guarantees have been made to me concerning the results of this procedure and that the professional recommendation is a NATURAL LOOK. _____ (initial)
- I understand the nature of the procedure and possible complications or adverse effects that may occur as a result of applied pigments. I fully understand this is a tattooing process; therefore not a science but an art.* _____ (initial)
- I have received and acknowledged pre- and post- procedure instructions and agree to strictly adhere to such instructions. _____ (initial)
- I accept responsibility for determining the color, shape, and position of the pigments that will be applied. I understand the actual color of the pigment may be modified slightly due to the tone & color of my skin. _____ (initial)
- I understand the taking of before and after photographs of procedures are required. _____ (initial)

* The known possible complications from micropigmentation are: redness, swelling, puffiness, bruising, dry patches and tenderness. It is normal to lose approximately 1/3 of the color during the healing process. After most procedures the color may be a shade too dark; in 6 days it will appear too light. After 10 days the color will show more initially. It will appear softer when completely healed as the color will come from the dermal layer of the skin to the epidermal layer of the skin. In the event of a CAT scan or MRI, please inform your physician of your Iron Oxide Permanent Cosmetics as some pulling or burning sensation may occur during the procedure.

_____
Clients signature Date

_____
Witness signature Practitioners signature Date

CLIENT RECORDS

Name:______________________________________ Age:______

Skin Type: Transparent/ Translucent/ Olive/ Sallow/ Peach/ Ruddy/ African

Treated Area: brows/ eyeliner/ lips/ areola

1. Date:____/____/____ Procedure Start: ___:____ Procedure Finish: ___:____
   Topical: ________________ Needle Size: _______ Tolerance: __________
   Pigment(s):____

2. Date:____/____/____ Procedure Start: ___:____ Procedure Finish: ___:____
   Topical: ________________ Needle Size: _______ Tolerance: __________
   Pigment(s):____

3. Date:____/____/____ Procedure Start: ___:____ Procedure Finish: ___:____
   Topical: ________________ Needle Size: _______ Tolerance: __________
   Pigment(s):____

Treated Area: brows/ eyeliner/ lips/ areola

1. Date:____/____/____ Procedure Start: ___:____ Procedure Finish: ___:____
   Topical: ________________ Needle Size: _______ Tolerance: __________
   Pigment(s):____

2. Date:____/____/____ Procedure Start: ___:____ Procedure Finish: ___:____
   Topical: ________________ Needle Size: _______ Tolerance: __________
   Pigment(s):____

3. Date:____/____/____ Procedure Start: ___:____ Procedure Finish: ___:____
   Topical: ________________ Needle Size: _______ Tolerance: __________
   Pigment(s):____

Treated Area: brows/ eyeliner/ lips/ areola

1. Date:____/____/____ Procedure Start: ___:____ Procedure Finish: ___:____
   Topical: ________________ Needle Size: _______ Tolerance: __________
   Pigment(s):____

2. Date:____/____/____ Procedure Start: ___:____ Procedure Finish: ___:____
   Topical: ________________ Needle Size: _______ Tolerance: __________
   Pigment(s):____

3. Date:____/____/____ Procedure Start: ___:____ Procedure Finish: ___:____
   Topical: ________________ Needle Size: _______ Tolerance: __________
   Pigment(s):____

Notes