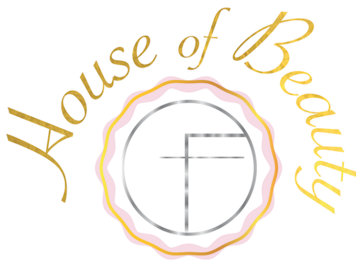

251 Princeton Hightstown Rd, Suite 03, East Windsor NJ, 08520

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 ☐ Correction ☐ Scar Camouflage ☐ Areola

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 a day	Why it was prescribed to you?

Practitioner Signature ____ Date _____/_____/_____

GENERAL MEDICAL Client Name: ______________________________

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
- [ ] Shingles History/Recent Shingles Shot
- [ ] 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	Boating	Walking
Golf	Skiing	Gardening	Other

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

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? __________

Physician's Name: ________________________________
Address: ____________________________________
Phone: _____________________________________
Specialty: ___________________________________

Signature of Practitioner ____ Date ____/____/________

INFORMED CONSENT TO PROCEDURE

1. Are you pregnant or nursing?

   Yes []   No []

Initial

2. 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. __________
3. I have received, reviewed and understand the pre-procedural instructions as given to me and agree to follow them. __________
4. 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. __________
5. I understand that the color selection and color results in all procedures are not an exact science. __________
6. 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. __________
7. 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. __________
8. If I am a lens wearer, I realize that I must keep my lenses out the day of an eyeliner procedure. __________
9. 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. __________
10. I realize this is an elective cosmetic procedure and is not medically necessary. __________
11. I have pre-medicated where indicated, prior to my procedure. __________
12. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling. __________
13. Although rare, Fever blisters may occur regardless of pre-medication. __________
14. 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. __________
15. I give my consent to House of Beauty to confer with my physicians for medical information required for the safety of my procedures. __________
16. 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. __________
17. 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***. __________
18. Services rendered by House of Beauty By François are nonrefundable __________

ACCEPTANCE:

I have read and understand these risks listed above and they have been explained to me. I certify that the information in the above questionnaire is accurate and my questions have been answered.

*****Please read all questions thoroughly before signing!!***

Client Name (Print) ______________________________ Signature of Client X_________________________________

Signature of Practitioner ____Date _____/_____/ _______