**CLIENT INFORMATION SHEET**

NAME Date of Birth: ADDRESS

PHONE (Day) Night May we contact you at these numbers if necessary? Yes No

PROCEDURES DESIRED:

Eyeliner

Beauty Mark

Eyebrows

Lipline

Full Lip Color

Nipples

Skin Repigmentation

Other

If you selected “other” please explain:

Have you **ever** had a cold sore? Yes No If yes, you must contact your physician for a prescription of ZOVIRAX capsules, an antibiotic which prevents cold sores.

I have read the above information regarding ZOVIRAX and understand its use is mandatory if I desire lipline or full lip color procedures.

\*Signed: (Client)

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Who referred you: Are you currently under the care of a physician? Yes No

If so, why? Physician’s name:

Do you take antibiotics when going to the dentist? Yes No If Yes, Why?

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 which thins the blood? Yes No

|  |  |  |  |
| --- | --- | --- | --- |
| Are you taking other medications? | Yes | No If yes, explain: |  |
| Are you pregnant or nursing?  Do you wear contact lenses? | Yes  Yes | No  No |  |

I understand that if I fail to cancel my appointment within 24 hours, there will be a charge of $

\*Signed: (Client) Date: