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GENERAL CONSENT FORM

Name _____ Date of Birth _____
 Last First
 Address _____
 City _____ State _____ Zip code _____
 Phone (home) _____ (work) _____ (cell) _____
 Email Address _____ How did you hear of this service? _____
 Driver's License No. _____ ID checked _____

Health Assessment

Do you or have you had:	No	Yes	Do you have a history of any of the following:	No	Yes
Jaundice, hepatitis, AIDS or positive HIV test	___	___	Skin disease or skin cancer at the procedure site?	___	___
Diabetes	___	___	Allergies or anaphylactic reaction to pigments/ dyes or other sensitivities?	___	___
Seizures, fainting or narcolepsy	___	___	Hemophilia or excessive bleeding? Taking medica- tion which thins blood and/or interferes with clotting?	___	___
Currently pregnant or breast feeding	___	___	Any condition which impairs healing or increases infection?	___	___
Mitral Valve Prolapse	___	___	Glaucoma, Cataracts, Eye Disease, Dry Eye	___	___
Plastic Surgery/Collagen within past 6 months	___	___	Heart Condition/Pacemaker	___	___
Herpes Simplex (cold sores/fever blisters)	___	___	Are you allergic to latex?	___	___
Take medication prior to dental work	___	___	Have you ever used Alpha Retinol/other acids?	___	___
Do you smoke	___	___	Ever had laser, phenol/other medical procedure?	___	___
Ever taken Acutane; how long ago	___	___			
Contact Lens/ TAKE OUT for liner procedure	___	___			
Brows / Electrolysis lately? Tweezed brows?	___	___			

Current Medications

Currently under care? _____ Physician _____ (phone) _____

I hereby authorize Specialist to perform the following procedure(s): (circle all that apply)

Brows ___ Eyeliner/Both ___ Upper ___ Lower ___ Full Lip Color ___ Beauty Mark ___ Areola ___

PROCEDURE CONSENT: I fully understand that the nature of the procedure being used is micro-insertions of pigment into the dermal layer of the skin. The methods of application and the possibility of complications and risks has been fully explained to me. These risks include, but are not limited to:

- Pigments can and will fade. It is my responsibility to schedule touchups due to personal preference. I understand that there will be a fee for these services, determined at that time.
- Infections can occur if you do not follow after care procedure sheets.
- There are few effective methods for pigment removal. Removal involves a medical procedure.
- Allergic reactions to topical anesthetics and/or pigments can occur.

Please read and sign "Yes" or "No" to the below statements:

_____ I consent to the taking of "before" and "after" photos for charting purposes (Must be Yes).
 _____ I consent to the taking of photos for advertising purposes.
 _____ I consent to the use of showing my photos to new clients only (Must be Yes).
 _____ I will not be able to donate blood for 1 year per the guidelines of the American Red Cross (Must be Yes).

I acknowledge that the final outcome of this procedure will not be obtained during the first visit, that it may take more than two applications to achieve the desired results; applications are scheduled 5-7 weeks apart. I am required to come back for one perfecting session per procedure; I will be charged an additional fee if touch-up visit is not performed within ten weeks of initial procedure unless prior arrangements are made. I understand that no warranty or guarantee has been made to me as to the final results. I certify that I have read, had explained to me and fully understand the above consent and procedure permit, and that I accept full responsibility for any complications which may arise or result during or following the cosmetic procedure which is to be performed at my request. All blanks were completed prior to my signature below.

Signature of Client _____ Signature of Technician _____

Date: _____