**Patricia, PMU Professional**
**Facial Art Permanent Cosmetics**
**Located at Images on Mack**
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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 _____

**MEDICAL HISTORY: Please circle and explain if you have ever had or currently have or take:** Acutane or have any Allergies of any kind, Diabetes, Carcinoma, Heart Condition, Mitral Valve Prolapse, Pacemaker, Herpes Simplex (Cold Sores/Fever Blisters), Plastic Surgery or Collagen within the past 6 months, Contact Lens, Hepatitis, HIV, Glaucoma, Cataracts, Eye Disease, Dry Eye, have had Electrolysis lately, Tweezed brows lately. **Are you pregnant ?___ Or required to take medication prior to dental work?___**
**Do you smoke?**
**Current Medications**_____
Physician_____ **Currently under care?**_____
(phone)
**I hereby authorize Specialist to perform the following procedure(s): (circle all that apply)**
**Brows_____ Eyeliner: Upper_____ Lower_____ Both_____ Full Lip Color_____ Beauty Mark_____**

**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.
- Allergic reactions to topical anesthetics and/or pigments can occur.

I acknowledge that the final outcome of this procedure will not be obtained during the first visit, and that it may take more than two applications to achieve the desired results. These applications are scheduled 5-7 weeks apart. I am required to come back for one pefecting session per procedure and that 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.

**Colors will appear brighter and more sharply defined immediately after the procedure. As the healing progresses, color will soften.**

**Please read and initial the below statements:**
_____I consent to the taking of "before" and "after" photos for charting purposes (this is a MUST).
_____I consent to the taking of photos for advertising purposes (I will respect your wishes).
_____I consent to the use of showing my photos to new clients (this is a MUST).
_____I have been informed that **I will not be able to donate blood for 1 year** due to the guidelines of the American Red Cross.

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:_____