RiseandShinePermanentMakeup.com

Initial appt: _____
Followup/Annual: _____

CLIENT CONTACT INFORMATION

Name _____ **Phone ( ) -** _____ **Email** _____

Address _____ **City, State, Zip** _____

DL#/ID# _____ **Birthdate** _____

MEDICAL HISTORY

Please circle "yes" or "no" if you have ever experienced …

Epilepsy	Yes	No	Latex Allergy	Yes	No	Nickel Allergy	Yes	No
Hemophilia	Yes	No	Facial Skin Cancer	Yes	No	Latex Allergy	Yes	No
Heart Condition	Yes	No	Alopecia	Yes	No	Lidocaine, Tetracaine, Epinephrine Allergy		
High/Low Blood Pressure	Yes	No	Eye Disease	Yes	No		Yes	No
Pacemaker	Yes	No	Glaucoma	Yes	No	Are you wearing contacts?		
Keloid Formation	Yes	No	Cold Sores	Yes	No		Yes	No

LIFESTYLE ANALYSIS

How often are you in the sun, natural or artificial UV light? _____ hrs _____ min per day / week
Do you wear sunscreen on your face? Y N
Do you wear sunscreen on your lips? Y N
List face creams, lotions, serums? _____
Have you used Retin-A in the procedure area within 3 months? Y N
Have you used Acutane in last year? Y N
Do you color your hair? Y N If yes, are you planning on changing your haircolor by 2 or more shades in the future? Y N
Have you had plastic surgery, fillers, Botox in the procedure area within last 6 months? Y N
Do you plan to have plastic surgery, Fillers, Botox, involving the procedure area, in next 6 months? Y N
Do you have any concerns? any other pertinent medical history not mentioned above? _____
Do you have any allergies? Food additives, Color Additives, Topical Creams, etc.? _____
Have you ever had an adverse reaction to cosmetics? Yes No Explain: _____

CONSENT AND RELEASE AGREEMENT

I hereby authorize Rise and Shine to perform the following elective procedure(s): ____ Eyebrows _____ Upper/Lower Eyeliner ____ Lip Liner ____ Lip Color Blending ____ Microblading

I fully and voluntarily consent to have Veronica Morris perform cosmetic tattoo procedure(s) and am aware and informed of the risks and complications that may occur, which may include, but are not limited to: scarring, infections, allergic reactions, corneal abrasions, herpes (cold sore) outbreaks, eye injury, swelling, pain, bruising, minor bleeding, redness, soreness, hyper-pigmentation, etc. This is an elective, minimally invasive procedure. I have asked all questions regarding risks and complications and received satisfactory answers. X_____ (initial)

I understand the process used to apply is not a one-step process and requires subsequent visits to achieve desired results. Corrective Color/placement visits for clients with previous permanent Makeup may require more than one followup. Maintenance visits are scheduled from 3 months to 3 years. The fee is determined by time between visits. X_____ (initial)

I accept full responsibility for determining shape, color and position of the pigments applied. X_____ (initial)

I acknowledge that cosmetic pigments can heal inconsistently, spread or fan, and will peel and soften. I understand that the cosmetic tattoo(s) will appear darker immediately after the procedure than it will one week later. Within three to four days after the procedure, the outer layer of pigment will begin to slough off and the tattoo will then appear smaller, lighter, softer and less de-

fined. X_____ (initial)

I understand with time pigment can and will fade and change color according to metabolism, skin type, medications, face products in form of creams, lotions, serums, etc, macrophage activity, sun exposure, and age. And over time based on the darkness of the pigment , saturation and client care pigments loose color in the sun. X_____ (initial)

I understand that no guarantees have been made to me concerning the results of this procedure and professional recommendation is natural look. X_____ (initial)

I have received and acknowledge After-care Instructions. I agree to strictly follow such instructions for best healed outcome. X_____ (initial)

The Client **CONSENTS TO** or **WAIVES** (circle one) a patch test prior to the procedure. Patch test fee $20 and results must be viewed 24-48 hours after test.

I am responsibility to schedule follow-up appt to be done 3 to 6 weeks after previous procedure. if scheduled within said time period setup/service fee of $35 dollars will apply. After 6 weeks Maintenance appt fee schedule applies. X___ (initial)

If I am having a Lip Procedure I will obtain a prescription for Zovirax, Valtrex or some other prescription cold sore medication from my doctors and take as prescribed for this procedure .X_____ (initial)

I understand that pre and post pictures are required and ____ may or _____may not be used for marketing/educational assets.

I certify that I am over the age of 18, have read and fully understand this Consent and Release Agreement.

Signature of Client _____ **Date** _____

Signature of Technician/Veronica Morris _____ **Date** _____

Technician Use

Virgin / Corrective/ Refresh Date _____***Desired Color*** _____ ***Current Color*** _____
Formula _____***Shape/Design Preferences*** _____
Scars _____***Sym /Asym Origin / Arch / End Anesthetics: Dotc Blue/Numbquick Pink/Comfort Cream/Numbpot Gold/Tag 45/Magic***

Needle Size _____ ***Machine*** _____ ***Pain Tolerance*** _____ ***Relaxation/Stress*** _____

Movement_____ ***Notes***_____

_____

Virgin / Corrective/ Refresh Date _____***Desired Color*** _____ ***Current Color*** _____
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Movement_____ ***Notes***_____

_____

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Movement_____ ***Notes***_____

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