Zink Modern Tattooing
503 Main Street, Butler, NJ, 07405

**Today's Date**: _____/_____/_____

**Client Info**:
Name: _____ Date of Birth: ___/___/___ Email: _____
Ethnic Background (Please include all nationalities):_____
Address: _____ Apt. #: _____ Home Phone: (_____) _____-_____
City: _____ State: ____ Zip Code: _____ Cell Phone: (_____) _____-_____
Occupation: _____

If we call you at home, do you want confidentiality? ( ) Yes ( ) No

May we call you at work? ( ) Yes ( ) No If yes, my work number is (____) ____-_____

**Emergency Contact Information**:
Name: _____ Phone: (_____)_____-_____ Relationship: _____

**Who may we thank for referring you?** _____

**Procedure(s) desired**: ( ) Brows ( ) Eyeliner ( ) Lips

**List all medications you are presently taking**

| Name of Drug | mg or mcg | Amount/Day | Why was it 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 | Amount/Day | Why was it prescribed to you? |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**Practitioner Signature**: _____ Date: _____/_____/_____

# GENERAL MEDICAL

**Client Name: _____**

# 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:* _____

**Physician's Name**: _____
**Address**: _____
**Phone**: (___) ___-____ **Specialty**: _____

**DO YOU USE (CHECK ALL THAT APPLY:**

( ) Accutane (currently or within the past yea
( ) 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?* _____

**Signature of Practitioner:** _____
**Date:** _____

## INFORMED CONSENT TO PROCEDURE

*(PLEASE READ ALL QUESTIONS THOROUGHLY BEFORE SIGNING)*

**Initial**

INFORMED CONSENT TO PROCEDURE
(PLEASE READ ALL QUESTIONS THOROUGHLY BEFORE SIGNING)

**1.** Are you pregnant or nursing? ( ) Yes ( ) No

_____

**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 and post-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, lip liner 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 Restylane, 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**. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment.

_____

**12**. 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 makeup dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent make up.

_____

**13**. I give my consent to Love Your Look Beauty Studio to confer with my physicians for medical information required for the safety of my procedures.

_____

**14**. 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.

_____

**15**. I am aware that if an infection occurs after I have received Permanent Cosmetic to see with my primary physician or an emergency room immediately.

_____

**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.

**Signature of Client**: _____ **Date Signed**: _____/_____/_____

**Signature of Practitioner**: _____ **Date Signed**: _____/_____/_____

# PHOTOGRAPH AND PUBLICITY RELEASE FORM

I, _____, give my permission to use my likeness, image, and/or appearance as such may be embodied in any pictures, photos, video recordings, digital images, and the like, taken or made on behalf of Love Your Look Beauty Studio. I agree that Love Your Look Beauty Studio has complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with the Love Your Look Beauty Studio mission. These uses include, but are not limited to illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials in any medium now known or later developed, including the Internet. I acknowledge that I will not receive any compensation, etc. for the use of such pictures, etc., and hereby release Love Your Look Beauty Studio and its agents and assigns from any and all claims which arise out of or are in any way connected with such use.

I have read and understood this consent and release.

I give my consent to Love Your Look Beauty Studio to use my likeness to promote the company, and/or their activities.

_____

**Signature** **Date**

_____

**Print Name**

**Client Name**: _____ **Date**: ____/____/_____

**Procedure Type**: _____

| Tool/Product | Brand | Lot Number | Expiration |
|---|---|---|---|
| Needle(s) | | | |
| Topical Anesthetic(s) | | | |
| Pigment(s) | | | |
| Other Product(s) | | | |

**PROCEDURE NOTES**:

_____

_____

_____

_____

_____

**Practitioner Signature**: _____ **Date**: _____/_____/_____