

Forever Flawless Intake

Artist: Paige Pozos

Name: _____ Date _____

Address _____

City _____ ST _____ Zip code _____

Cell Phone (_____) _____ Email _____

Emergency Contact Information: Name _____ Phone# _____

How did you hear about me? _____

PHOTO RELEASE: Client authorizes unrestricted use of before and after photographs to include, but not limited to, portfolio, internet and teaching. Initial _____

MEDICAL HISTORY: Physician's name _____

Please list any prescriptions, herbs, vitamins you are taking or any medical issues :

Location(s) of Procedure? _____

What do you use for your current skin care? _____

_____ I have read my preappointment instructions. I understand that sun, tanning beds, pools, skin care products and medications can negatively effect my permanent makeup Especially Eyebrows.

_____ I understand this is permanent, but also requires maintenance ranging from 1-10 years. (brows require the most to keep looking good 1-3 years Liner & Lips 1-10 years) Clients will be offered a discounted rate of _____ for future appointments.

BROW CLIENT Only: Pigment Selection CIRCLE ONE

Recommended Organic (fades ashy / Cool over time) Inorganic (fades warm/Orange over time)

Do you use Retin A, Renova, Harsh Acne Treatments or Glycolic Acids regularly? Yes or No

You understand you must be off Accutane 1 year prior all to procedures _____ Initial

_____ I have been informed that having Tanning, Sun Damage, Using AntiAging or Antiacne products, or changing my pigmentation near procedure area at any point, can and will cause the pigments to change to an unnatural color: fade prematurely, look ashy or gray, appear more powdered looking or not retain at all. I wish to proceed & accept these risks and will hold Forever Flawless, LLC and/or her associates harmless if the above said risks occur. I take full responsibility & accept that this will/could occur. I further understand that appointments will not be made any sooner if the above issues occur.

Have you had shingles or auto immune issues in the last 6 months or ever? _____

Have you ever had Permanent Makeup ? Yes or No By whom, and how long ago? _____

If yes: You understand that corrections may require additional sessions? Yes or No

Are you allergic to any of the following ? Please circle YES/NO If yes, please circle below.

Glycerin Epinephrine Caine Products Warm Color Pigment

Do you have any facial plastics, filler, botox etc? Yes or No

Do you take any of the following medications? Please circle YES – NO If yes, please circle below.

Accutane Insulin Blood thinners Aspirin Anti-coagulants Latisse Thyroid Medication

Are you Pregnant Breast Feeding? YES or NO *Have you had chemo in the last year? YES or NO

_____ I understand that, and agree, if I have ever had a fever blister or cold sore I will take a prescription medication from my doctor or dentist for a lip tattoo. (You must take Valtrex or Zovirax orally before and during any lip tattoo procedures)

_____ I understand that a certain amount of discomfort is associated with this procedure and that minor or temporary swelling, redness, or fever blisters may occur on the lips following lip tattoo procedures. Fading or loss of pigment can occur. I understand that successful lip saturation cannot be guaranteed due to hidden scar tissue.

_____ I understand the permanent makeup is a multi-session procedure requiring more than one visit to perfect. **From 1-3 sessions depending on the individual.** All procedures take at least 30 days to heal and evaluate.

_____ Client must wait one month following any tattoo before donating blood.

_____ I acknowledge that the proposed procedure(s) all involve inherent risks and the possibility of complications (provided to comply with health code regulations) including, but not limited to: abscesses, allergies, excessive bleeding, heavy metal poisoning, infection (symptoms: fever, swelling, redness), keloid formation, muscle and/or nerve paralysis, scarring, bloodborne pathogen, tongue swelling, throat closure, tooth fracture, misplaced pigment, poor color retention, hyperpigmentation.

*If complications arise: please consult a medical provider. (*For Montana residents: please also report adverse reactions to Riverstone Health @ 406-256-2770)

_____ I hereby consent to having permanent makeup applied by Paige Pozos. I have answered all questions truthfully and to the best of my knowledge; and understand that this is considered a permanent procedure.

_____ I have read and received, as well as understand, my after care. I further understand the differences between traditional tattoo healing and permanent cosmetics healing and aftercare.

_____ I understand I can have an allergy patch test by request.

I understand there will be no refunds upon treatment for this elective procedure(s). I understand my payment includes one visit within 90 days of initial application. It is the responsibility of the client to contact Forever Flawless 30 days after initial session if a touch up is required. **Additional visits for touch ups will require further payment.** I understand that if I do not do the touch up within 90 days that my procedure will not be guaranteed and qualify for the return client maintenance discount.

_____ I certify that I have read and understood all of the above

Additional: _____ Initial _____

Signature of Client: _____ Date: _____

Signature of Practitioner: _____ Date: _____