



permanent cosmetics and skin care

# Permanent Cosmetics Medical Form

PLEASE READ CAREFULLY AND SIGN WHERE INDICATED, Only when you are ready to Proceed and have discussed all points with specialist. You are signing you fully understand and accept the terms of Treatment you are having today. You will be given Aftercare products and full written instructions.

Valid ID Info (DL) \_\_\_\_\_ Age \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Cell Phone \_\_\_\_\_

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_  
No. & Street City State Zip

Work Address: \_\_\_\_\_  
No. & Street City State Zip

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Are you now or have you been under the care of a physician within the last two years? \_\_\_\_\_  
If yes, please provide Physician's Name, address and phone number. \_\_\_\_\_

Person to contact in an emergency: \_\_\_\_\_  
Name  
Address & Phone No.

List all medications you are currently taking, including Retin A, Glycolic Acid and Acutane: \_\_\_\_\_

List any drug, makeup, skin or food allergies (i.e., soaps or cleansing creams): \_\_\_\_\_

Do you feel fit and well to have Permanent Cosmetic Treatment today? \_\_\_\_\_

Permanent Cosmetics is an art process - not an exact science and I / Donna or Velvet Touch Permanent Cosmetics & Skin Care, LLC cannot guarantee, and exact shrinkage result due to skin elasticity and individual healing.

I, \_\_\_\_\_ you have chosen Permanent Cosmetic procedure that is not medically necessary:

Sign: \_\_\_\_\_ Date \_\_\_\_\_



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I, \_\_\_\_\_ understand the importance of my accurate and full disclosure of my Medical History. Withholding any medical Information may could cause serious issues to my health and safety during this procedure. It is my responsibility to inform specialist accurately.

Are you pregnant? Or maybe \_\_\_\_\_ If Yes, we cannot proceed with this treatment today.

**Do you have or have you had any of the following conditions (answer all Yes or No):**

- |                                       |  |
|---------------------------------------|--|
| _____ Abnormal Heart Condition        | _____ Do you have face injections        |
| _____ <b>Cold Sores/Fever Blister</b> | _____ "Dry Eye"                          |
| _____ <b>Herpes Simplex</b>           | _____ Corneal Abrasions                  |
| _____ <b>Botox last used</b> _____    | _____ Eye Surgery or Injury              |
| _____ Hemophilia                      | _____ Blepharoplasty (eyelid surgery)    |
| _____ High or Low Blood Pressure      | _____ Visual Disturbances                |
| _____ Prolonged Bleeding              | _____ Cancer                             |
| _____ Circulatory Problems            | _____ Tumors/Growths/Cysts               |
| _____ Epilepsy                        | _____ Chemotherapy/Radiation             |
| _____ Diabetes                        | _____ <b>Are you pregnant?</b>           |
| _____ Fainting Spells/Dizziness       | _____ <b>Hepatitis</b>                   |
| _____ Cataracts/Glaucoma              | _____ <b>Do you wear contact lenses?</b> |
| _____ ProLapsy Valve (Heart) meds?    | _____ Do you use tobacco products?       |
| _____ Do you have Botox               |  |

\_\_\_\_\_ **Have you ever experienced hyper pigmentation** from an injury?

\_\_\_\_\_ **Are you currently taking aspirin or ibuprofen?**

\_\_\_\_\_ **Do you have any respiratory problems?**

**I you checked any "yes" above please describe** \_\_\_\_\_

**Do you have any heart problems?** \_\_\_\_\_

When was your last eye exam? \_\_\_\_/\_\_\_\_/\_\_\_\_ Physician? \_\_\_\_\_

Do you use tobacco products? \_\_\_\_\_ Do you consume Alcohol? \_\_\_\_\_

Have you recently undergone a skin peel recently? \_\_\_\_\_

What type of Chemical Peel did you have? \_\_\_\_\_

What products do you use for skin care? \_\_\_\_\_

Are you planning on Injectables? Fillers, chemical peels soon? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



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**PMU DISCLOSURE AND TREATMENT CONSENT**

I, \_\_\_\_\_ as a client have requested that you describe the procedure to be utilized so that I may make an informed decision whether or not to undergo the procedure. The Specialist has described the recommended procedure to be used as Micro Pigment Implantation, the process of implanting micro insertions of pigment into the dermal layer of skin. Micro pigment Implantation is a form of tattooing used for the purpose of permanent cosmetic makeup and skin imperfection camouflage.

I, \_\_\_\_\_ fully understand and have been advised of any/or all risk and accept complete responsibility and release Donna and/or Velvet Touch Permanent Cosmetics & Skin Care LLC from any.

\_\_\_\_\_ I voluntarily request as my intradermal cosmetic technician, Donna Furr and such association and technical assistance as she may deem necessary to perform on my body the following procedure: Circle which applies:  
UPPER EYELID LOWER EYELID LOWER MUCOSAL EYELID EYEBROW FULL LIP COLOR LIPLINER AREOLAS CAMOUFLAGE STRETCH MARKS

\_\_\_\_\_ I hereby authorize Donna Furr to take photographs of the work performed both before and after treatment, and I further authorize the use of said photographs to be used for the purpose of advertising.

\_\_\_\_\_ I hereby authorize Donna Furr to take photographs of the work performed both before and after treatment to be maintained only in file.

\_\_\_\_\_ I understand that this description of the procedure is not meant to scare or alarm me. It is simply an effort to make me better informed so that I may give or withhold my consent for this procedure.

\_\_\_\_\_ I understand I will need to maintain the color with future applications. Sun, skin care products, pools and other factors play a role in pigment fading on the face as well as some medications. An allergic reaction may occur, possibly with topical agents or after care.

\_\_\_\_\_ I have been told that a follow up procedure may be required and that the color may fade over a period. Micropigmentation are not exact science and cannot guarantee exact retaining of all pigments implanted at time of procedure. Everyone will heal differently for no skin is the same due to numerous types.

\_\_\_\_\_ I have informed Donna Furr that I am in good health and not under the care of any physician.

\_\_\_\_\_ I am currently under the care of Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, ST, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

I am being treated for the following condition(s): \_\_\_\_\_

\_\_\_\_\_ I understand that if I have an infection, adverse reaction or allergic reaction to the procedure, I must notify Donna Furr or, a health care practitioner TEXAS Department of Health, Drugs and Medical Devices Division, at 1-888-839-6676.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**PMU DISCLOSURE AND TREATMENT CONSENT**

I, \_\_\_\_\_ Fully understand there are **No warranty or Guarantees** that have been made to me as to the results. There are **No Refunds** for this elective treatment procedure(s).

\_\_\_\_\_ I understand that there is a possibility of hyperpigmentation resulting from a procedure, especially in individuals prone to hyperpigmentation from a scar or other injury. You may want to consider a Patch Test.

\_\_\_\_\_ I understand that if I choose a patch test with pigment to be used does not guarantee that I may not develop an allergic reaction in the future to any product. Yes \_\_\_\_\_ No \_\_\_\_\_ *“Patch test requested”*

\_\_\_\_\_ I have been told that there may be risks and hazards related to the performance of the procedure planned for me. I have been told that this procedure could involve pain and discomfort.

\_\_\_\_\_ I have been told that the markings are permanent and there is a risk of pigment migration and infection following the procedure. I accept the responsibility for this procedure to follow aftercare as instructed.

\_\_\_\_\_ I have been told that there is always a follow up if needed in 6-8 weeks allowed at no additional cost. Then you will need to refresh 1-2 years depending on the color and your lifestyle to protect from fading sooner.

\_\_\_\_\_ I have been told that there is a chance that I may experience a corneal abrasion from the eyeliner procedure.

\_\_\_\_\_ I have been told that there is a chance of allergic reaction to pigment(s) or other materials used and that my body may reject the pigment.

\_\_\_\_\_ I have been given an opportunity to ask questions about the procedures and Donna explained to me how to avoid these risks and contaminations involved. I believe that I have enough information to be informed for consent.

\_\_\_\_\_ I have agreed that should I have a complaint of any kind whatsoever, I shall immediately notify Donna Furr and I further agree that any controversy or claim arising out of or relating to this consent and/or any signed contract between myself and Donna Furr or the breach thereof, shall be settled by arbitration in the state of TEXAS in accordance with the Rules of the American Arbitration Association and judgment of the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

\_\_\_\_\_ I have received a copy of the Permanent Cosmetic aftercare instructions for the type of procedure I elected to have done. It has been fully explained to me and I understand its contents. I will adhere to the written Aftercare instructions for my safety which was given to me after treatment

I, \_\_\_\_\_ understand and hereby consent to receiving Permanent Cosmetics. Donna has explained the terms and conditions of the process that I fully understand. I hereby give written consent to my specialist who is fully trained and insured to carry out the treatment of my choice as I requested a Permanent Cosmetic Treatment/s.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date