



CLIENT INFORMATION SHEET

NAME _____ Date of Birth: _____

ADDRESS _____

Cell Phone: _____

May we contact you at these numbers if necessary? Yes No

PROCEDURES DESIRED:

- Eyeliner Eyebrows Lipline Full Lip Color Areola
 Beauty Mark Skin Repigmentation Other _____

If you selected "other" please explain: _____

Have you ever had a cold sore? Yes No If yes, you must contact your physician for a prescription of ZOVIRAX capsules, an antibiotic which prevents cold sores.

I have read the above information regarding ZOVIRAX and understand its use is mandatory if I desire lipline or full lip color procedures.

*Signed: _____ (Client)

Who referred you: _____

Are you currently under the care of a physician? Yes No

If so, why? _____

Physician's name: _____

Do you take antibiotics when going to the dentist? Yes No If Yes, Why? _____

Do you suffer from: Allergies Moles or freckles at site of tattoo Hepatitis

Heart Problems Hemophilia Diabetes Skin Problems Scarring (Keloids)

Eye Problems Epilepsy Other: Please explain: _____

Are you presently taking any medication which thins the blood? Yes No

Are you taking other medications? Yes No If yes, explain: _____

Are you pregnant or nursing? Yes No

Do you wear contact lenses? Yes No

I understand that if I fail to cancel my appointment within 24 hours, there will be a charge of \$ _____

*Signed: _____ (Client) Date: _____