

 **CLIENT DETAILS- COSMETIC TATTOOING**

**(The information supplied is confidential and for professional use only)**

|  |  |
| --- | --- |
| Name |  |
| Address |  |
|  Contact number |  |
| email |  |
| Date of Birth |  |
| Date of appointment |  |

**Please answer the following question related to your health.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***All treatments*** | **Yes** | **No** | **Procedure for Eyebrow, Eyeliner** | **Yes** | **No** | **Procedure for Lips** | Yes | No |
| Diabetes |  |  | Glaucoma |  |  | Cold sores |  |  |
| Heart conditions |  |  | Eye infection |  |  | Filers |  |  |
| Hepatitis |  |  | Contact Lenses |  |  |  |  |  |
| Blood Disorder/Thinners |  |  | Botox |  |  | Botox |  |  |
| Communicable Diseases |  |  | Communicable Diseases |  |  | Communicable Diseases |  |  |
| Allergies |  |  | Allergies |  |  | Allergies |  |  |
| Pregnant |  |  | Pregnant |  |  | Pregnant |  |  |
| Other  |  |  | Other |  |  | Other |  |  |

 Anaesthetic Yes No Please initial…………………………………………………….

You have consulted with your Pharmacist who has provided you with appropriate topical anaesthetic. This may contain Lignocaine, Tetracaine, Prilocaine and /or epinephrin. Do you give your approval for these creams and lotions to be used before and during your proceedure?

 Please Circle Yes No

Have you had Cosmetic Tattooing before? YES NO

How did you hear about **Sueperb?**

Referral Face Book Instagram Google Search Expo

Other- Please give details.........................................................................................................................................

....................................................................................................................................................

|  |  |
| --- | --- |
| I understand that this treatment is for cosmetic enhancement purposes only. No guarantees have been made to me regarding the results including fading. |  |
|  I am responsible for the “At home after care” which may have risks of infection or fading of pigments if this is not carried out correctly. |  |
| I consent to before and after photos of this procedure which can be used for marketing purposes. |  |
| I will not hold the Therapist responsible in the event of any damage and shall not be entitled to take any action against her at Law and Equity for such treatment. |  |
| I am aware that I cannot give blood for 6 months (Universal Law) |  |
| I am over 18 years old (Health Act) |  |
| I have had the opportunity to ask questions relating to this treatment. |  |
| I am aware that more than 1 treatment may be necessary to achieve the best results.I am aware that LIP procedures may take more than 3 sessions to achieve the best results.There is a cost for perfecting sessions and follow up treatments are at an extra cost. |  |
| I understand that there are no refunds given. |  |
| I agree to a non -refundable deposit unless the appointment time can be filled |  |

In connection with the procedure of semi – permanent makeup is there any additional information you would consider relevant to share?

 No. Yes.....................................................................................................................

I agree that I have read and understood all questions and information on this client detail sheet and answered all the questions truthfully.

**Please sign if you agree to the above...............................................................................................**

**Date................................................................................................**

 Client’s Name....................................................................

D.O.B...................................................................................

Consent Forms signed. **YES**

Before Photos taken.  **YES**

ProcedureType...........................................................................................................................

Colour ....................................................................................................................................................

Shape

....................................................................................................................................................

|  |  |
| --- | --- |
|  **Pre -Treatment**I certify that I have been given the opportunity to discuss and choose the colour and shape for this procedure.  |  Signature...................................................................Date........................................................................... |
| **Post Treatment.**I am satisfied with the results obtained from this procedure and understand that colour and fade may vary as the skin heals. I discussed the post procedure after care and agree to follow instructions. | Signature.....................................................................Date.............................................................................. |

After Photos Taken **YES**

Feedback from Client

|  |
| --- |
|  |

Treatment Notes