

MICROBLADING PRE-PROCEDURE ADVICE

PLEASE READ THE FOLLOWING ADVICE CAREFULLY AND SIGN AT THE END

- Microblading procedures normally require multiple treatment sessions. For best results, clients will be required to return for at least one re-touch appointment. This will take place 4-6 weeks after the initial procedure. Those with oily skin may require an additional touch up. Please be aware that color intensity will be significantly darker and sharper immediately and a few days after the initial procedure, but the color will reduce by 30-50%
- Although numbing cream is used during the procedure, sensitivity or discomfort may still be felt. Skin may be red and/or swollen after the procedure.
- Please do not drink alcohol 24 hours prior to the treatment.
- A patch test can be performed, unless waived by client.
- Please do not shape or wax your brows before the procedure. Your technician will shape brows during the procedure.
- No electrolysis for at least 5 days before the procedure.
- Botox, AHA products and retinoids should be avoided for 2 weeks prior to the procedure.
- Exfoliating treatments such as microdermabrasion should not be performed within 2 weeks prior to procedure.
- Chemical and laser peels should be avoided no less than 6 weeks prior to procedure.
- Patients prone to cold sores/fever blisters should take an anti-viral prior to treatment.
- Hormone therapies can affect pigmentation and/or cause sensitivity.

TOPICAL ANESTHETIC ADVICE

ALLERGIC REACTION: Allergic reaction can occur from any anesthetics used during the procedure. If you do suffer from an allergic reaction, you should contact your doctor immediately. Allergic reaction response may show through redness, swelling, rash, blistering, dryness or any other symptoms associated with an allergic reaction.

NUMBNESS: We cannot accept responsibility if the area to be treated does not respond to the numbing cream. Each individual is different according to skin type. Some clients report the area to be completely numb, while others may experience some discomfort.

PROCEDURE: For microblading procedure, a numbing cream/gel is used. The products are formulated to be perfectly safe and can be purchased over the counter from any pharmacy/chemist. The anesthetic is placed over the treatment area for 20-30 minutes then carefully removed prior to treatment. As a result of the treatment, combined with the use of the anesthetic, you can expect to experience some redness/swelling that can last 1-4 days. You should always follow your post procedure advice and after care for the best results.

I have read and fully understand the above information provided and any risks involved with the use of topical anesthetic and I therefore consent to the use of the anesthetic for the microblading procedure.

I agree to follow pre- and post-procedure advice closely.

Client Name (please print)

Client Signature

Day/Month/Year

Cosmetic Professional

MICROBLADING: EYEBROWS

CLIENT INFORMATION FORM

APPOINTMENT DATE

APPOINTMENT TIME



EMAIL / NEWSLETTER

Occasionally we may send out emails or newsletters about upcoming discounts, promotions, contests, company information etc. If you would like to be added to the subscriber list please check "Yes" below. If you would like to opt out please check "No".

YES! Sign me up!

No, thank you.

We will use your e-mail address solely to provide information about our company. Your information will not be sold.

CLIENT INFORMATION (please print)

FULL NAME

ADDRESS

CITY

STATE / PROVINCE

ZIP / POSTAL CODE

PHONE

EMAIL ADDRESS

Have you ever had a cosmetic tattoo or microblading procedure before? yes no
If yes, when was your last procedure? _____

What would you like to improve about your eyebrows?
Consider shape, color, density, thickness...

Do you have moles/raised areas in or around the brow area? yes no

Do you have or have had a piercing in the brow area? yes no

Have you had a hair transplant for your eyebrows? yes no

FEMALE CLIENTS ONLY

Are you, or is it possible you may be pregnant? yes no

Are you currently breast feeding? yes no

CLIENT INFORMATION Continued

For a more effective, personalized treatment, please be as accurate as possible when filling out the following information

MEDICAL QUESTIONNAIRE

Are you prone to keloid scarring, hypertrophic scarring, or any other form of excessive scarring condition? Yes No

Have you taken a medication containing Isotretinoin (e.g. Roaccutane) during the previous 12 months? Yes No

Do you have, or do you think it is possible you may have a Blood Borne Communicable Disease?
e.g. Hepatitis C Virus (HBC), Hepatitis B Virus (HBC), Human Immunodeficiency Virus (HIV) Yes No

Do you currently have any other form of communicable disease, or infection?
e.g. respiratory infection, gastrointestinal infection, skin infection, ear or eye infection, bacterial, fungal or viral infection etc. Yes No

Do you have Diabetes, currently on any form of immuno suppressant therapy, or have any other condition that may cause delayed healing? Yes No

Have you ever had a Herpes Simplex Type I infection (also called cold sores/fever blisters)? Yes No

Do you have any Hypersensitivity, Auto-Immune Disorder, or Allergic Conditions? Yes No

Do you have a known allergy or sensitivity to any topical or local anesthetics including dental anesthetics? Yes No

Have you ever taken a medication containing Bisphosphonate/Diphosphonate?
(e.g. fosamax, alendronate) Yes No

Do you have any form of bleeding disorder, or are you taking any anticoagulants (blood thinners)? Yes No

Have you had any form of Cosmetic or Surgical Procedure, Radiotherapy, or Chemotherapy at any time during the past 6 months? Yes No

Do you suffer from any form of hyper-pigmentation skin conditions? Yes No

Do you suffer with fainting, blackouts, or seizures? Yes No

Do you have a cardiac pacemaker, Implanted Cardioverter Defibrillator (ICD), have a serious heart condition, or abnormal blood pressure? Yes No

Do you have any form of acute or chronic eye condition? Yes No

Are you prone to developing Telangiectasia?
(sometimes referred to as spider veins) Yes No

CLIENT INFORMATION Continued

SPECIAL PRECAUTIONS

Do you suffer from allergies? yes no
If yes, please specify _____

Are you currently taking any yes no
medications, herbs, vitamins? If yes, please specify

Do you have an allergy or yes no
sensitivity to latex/rubber?

Do you smoke? yes no

Do you have a known allergy or sensitivity to any
ingredients within tattoo pigments or needles, regular
makeup, any preservatives, yes no
hair dyes, or other dyes?

Do you have a known allergy or sensitivity to
any ingredients in tattoo aftercare creams,
antiseptics, lanolin, or petrolatum (petroleum
jelly)? yes no

Have you used any eyelash or eyebrow
growth serums / creams or any eye drops
that may contain prostaglandin analogues in
the past 4 weeks? yes no

Do you wear contacts? yes no

Is there any additional information about
you that we should know before starting
your treatment?

Please read the following statements carefully. Microblading is a way of cosmetic tattooing, intended to be semi- permanent lasting an average of 12-36 months. On rare occasions, the pigment may migrate under the skin. The procedure of microblading may be uncomfortable. Although extremely rare, there might be an immediate or delayed allergic reaction to pigment. A negative patch test result does not guarantee that you will not develop an allergic reaction after the full procedure. Allergic reactions to anesthetic can occur. Permanent cosmetics cannot be performed if you are pregnant or nursing, or anyone under the age of 18. Infections can occur if aftercare instructions are not followed correctly. There may be swelling and redness following the procedure. You may experience minor bleeding. If you have an MRI scan within 3 months after microblading procedure, you should notify/discuss with your doctor. Possible scarring may occur.

I have received after care information and I'm fully aware of the after care procedures. I fully understand the information provided above & confirm that all information provided by me is correct and truthful.

Client Name (please print)

Client Signature

Day/Month/Year

Cosmetic Professional

INFORMED CONSENT FOR MICROBLADING

I _____ am over the age of 18, am not under the influence of drugs or alcohol, am not pregnant or nursing and desire to receive the indicated semi-permanent pigmentation procedure. The general nature of cosmetic micro-pigmentation, as well as the specific procedure to be performed, has been explained to me.

_____ If an unforeseen condition arises in the course of the procedure, I authorize my therapist to use his/her professional judgment to decide what he/she feels is necessary under the given circumstances. I accept the responsibility for determining the color, shape and position of the microblading procedure as agreed during consultation. I fully understand and accept that non-toxic pigments are used during the procedure and that the result achieved may fade over a period of 1-3 years. Even once the color fades, pigment itself may stay in the skin indefinitely.

_____ I have been informed that the highest standards of hygiene are met and that sterile, disposable needles and pigment containers are used for each individual client, procedure and visit.

_____ I understand and accept that each procedure is a process requiring multiple applications of pigment to achieve desired results and that 100% success cannot be guaranteed during the first procedure. I understand that I may have to return for a repeat procedure.

_____ The result of the procedure can be affected by the following: medication, skin characteristics (dry, oily, sun-damaged thick or thin skin type), personal pH balance of your skin, alcohol intake and smoking, post procedure after care.

_____ Upon completion of the procedure there might be swelling and redness of the skin, which will subside within 1-4 days. In some cases, bruising may occur. You may resume normal activities following the procedure, however, using cosmetics, excessive perspiration and exposure to the sun should be limited until the skin has fully healed. Please see after care instructions for more details. The procedure results will look acceptable for you to appear in public without additional make-up on the brows.

_____ I have been advised that the true color will be seen 6 weeks after each procedure, and that the pigment may vary according to skin tones, skin type, age and skin condition. I understand that some skin types accept pigment more readily and no guarantee on exact color can be given.

_____ To my knowledge, I do not have any physical, mental or medical impairment or disability that might affect my well being as a direct or indirect result of my decision to have the procedure done at this time.

_____ I agree to follow all pre-procedure and post-procedure instructions as provided and explained to me by the technician. Failure to do so may jeopardize my chances for a successful procedure.

_____ I can confirm that I have received a copy of after care details.

_____ I have been informed of the nature, risks, and possible complications and consequences of permanent skin pigmentation. I understand the permanent skin pigmentation procedure carries with it known and unknown complications and consequences associated with this type of cosmetic procedure, including but not limited to: infection, scarring, inconsistent color, and spreading, fanning or fading of pigments. I understand the actual color of the pigment may be modified slightly, due to the tone and color of my skin.

_____ I fully understand this is a tattoo process and therefore not an exact science but an art. I request the semi-permanent skin pigmentation procedure(s) and accept the permanence of this procedure as well as the possible complications and consequences of the said procedure.

There is a possibility of an allergic reaction to numbing agent and/or pigments. A patch test is offered however it does not ensure a client will not have an allergic reaction. If waived, I release the technician from liability if I develop an allergic reaction to the pigment. Initial one or the other, not both: I consent _____ to the patch test OR I waive _____ the patch test

_____ I understand that if I have any skin treatments, injectables, laser hair removal, plastic surgery or other skin altering procedures, it may result in adverse changes to my microblading procedure. I acknowledge some of these potential adverse changes may not be correctable.

_____ I certify that I have read and initialed the above paragraphs and have had explained to my understanding the consent and procedure permit. I accept full responsibility for the decision to have this cosmetic semi-permanent pigmentation work done.

_____ I give _____ permission to perform my microblading procedure.

Client Name (please print)

Client Signature

Day/Month/Year

Cosmetic Professional

DISCLOSURE & RELEASE FORM

I UNDERSTAND THE FOLLOWING COMPLETELY: (PLEASE INITIAL EACH STATEMENT)

- _____ Microblading can last 12-36 months depending on how my skin reacts to the procedure. There may be fading and/or discoloration. The result may not be what I expected to receive. I understand this is a semi-permanent makeup procedure that may take numerous follow-ups and touch ups to get a desired result.
- _____ There is no warranty or guarantee made to me as a result of this procedure and the final result cannot be guaranteed. There are no refunds for this procedure, as results will vary and individual results are not guaranteed.
- _____ I have seen and agree with the pre-drawn shape that my artist created. I understand that this is a guideline for the shape and size of my brow design and it may vary slightly once the procedure is done.
- _____ There may be risks and hazard related to performing this procedure.
- _____ There may be discomfort and pain during this procedure.
- _____ There is a possibility of bleeding, swelling, redness and allergic reactions to pigments.
- _____ Microblading is considered semi-permanent and can/will fade over time.
- _____ Microblading, though semi-permanent, may last permanently and may not fade.
- _____ Surgical procedures may be required to remove pigment from skin. These procedures may cause scarring and permanent damage to the skin.
- _____ Final results cannot be determined until brows are completely healed at 4 to 6 weeks.
- _____ I understand that permanent and semi-permanent makeup procedures cannot be guaranteed and results cannot be predicted, as there are many variables that contribute to the final result, such as aftercare, skin type, lifestyle, etc.
- _____ I have received post care instructions and will follow them to ensure results of my procedure are satisfactory.
- _____ I am NOT pregnant.
- _____ I am NOT under the influence of drugs and/or alcohol or any other mind altering substance.
- _____ I fully understand the procedure and give permission to my technician to perform the service of Microblading and all procedure and steps involved.
- _____ I have truthfully filled out the consent form and have informed my technician of all medications I have taken.
- _____ I release _____ of all claims and injury, seen or unseen that may occur as a result of this procedure.

Client Name (please print)

Client Signature

Day/Month/Year

Cosmetic Professional

FOR PROFESSIONAL USE

MICROBLADING: EYEBROWS PERSONAL CLIENT INFORMATION

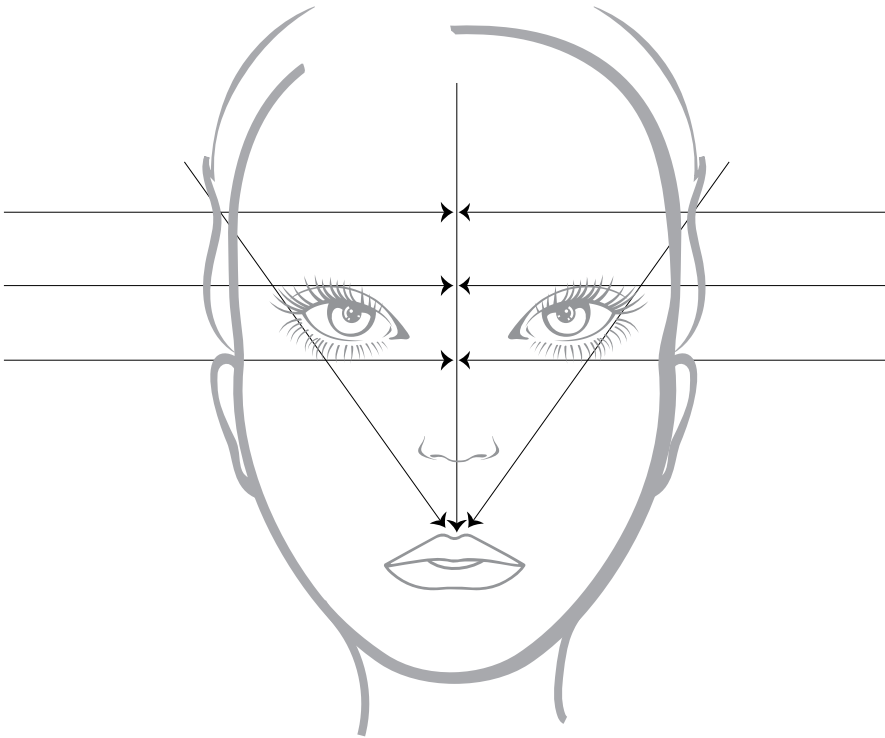
File Categorically by
First Letter Of
Clients Last Name



FILE

CLIENT FULL NAME

PERSONALIZED MICROBLADING CHART / NOTES



TREATMENT DETAILS

PIGMENTS USED

BLADES USED

TREATMENT NOTES & DESCRIPTION

FOLLOW UP / CHANGES:

TOUCH UP DATE:

TOUCH UP NOTES:

PRICING

Base Price: _____

Touch Up: _____

Other: _____

TOTAL: _____