Touch Of Beauty Inc.

Client Registration Form

Taking Beauty To The Next Level

****Please allow at least 15 minutes to complete this form.***

General Information

Name (Last) **:**_____ (First): _____ (M.I): ____ Preferred Name:_____

Date of Birth: Month: ____ Day: ____ Year: _____ Age: ____ □ **Male** □ **Female**

Address: _____

City: _____ State/Province: _____

Zip/Postal Code: _____ Residency: □ U.S. □ Canada □ Other

Home Phone: **( )**_____ Work Phone: **( )**_____ Cell:**( )**_____

E-Mail: _____ Preferred Contact: □ Home # □ Cell# □ Work # □ E-mail

Emergency Contact: _____ Phone: **( )** _____ Relationship:_____

Driver's License #**(required for check transactions)**:_____

Payment Method: □CASH □Check □VISA □MC □DISCOVER □AMEX □DEBIT

Which of the following influenced your decision to choose Touch of Beauty?(Please rank order with "1" being the most influential)

____Employer/Co-worker ____ Advertisements _____ Web Site (Internet)_____
____ Doctor ____ Friends/Family Who may we thank?_____
____ Other: _____

To Better understand My Clients, Please Answer the Following Or State "N/A".

Please share with us some of your favorite hobbies/activites. _____
How long have you been considering permanent makeup?_____
What is your motivation for permanent makeup?_____
Do you have any concerns or questions about permanent makeup?_____
What would you like to achieve with your permanent makeup? _____
Have you ever been excessively anxious, to the point of fainting at a dentist or doctor's office?
□NO □YES (if yes, please explain)_____
_____
Anything else we should know about you that we forgot to mention on this form?_____

PHOTO RELEASE AGREEMENT

I, _____**(Your Name)**, authorized Jennifer Phung to unrestrictive use of before and after photographs to include but not limited to her portfolio. I, _____ **(Your Name)**, fully understand and have ask all questions before accepting this agreement.

Please note that I must have before and after pictures of all my clients.

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Medical History

Physician's Name: _____ Physician's Number: _____

Do you have any allergies to the following:
□ **Latex** □**Cain ointments/solutions (ex: lidocaine)** □**Antibiotic Ointments** □**Epinephrine**
□**Others (please list):** _____
Please list any medication(s), herbs or vitamins you are taking _____

Do you use Retin A, Glycolic Acids or Renova (ingredients found in toners/cleansers) regularly?
□**NO** □**YES** (If yes, please discontinue two weeks prior to all procedures)

Do you use Accutaine "Isotretinoin"(acne medication)?
□**NO** □**YES** (If yes, please discontinue at least one year prior to all procedures)

Do you Smoke? □**NO** □**Yes** (If yes, how often?) _____

Do you wear any of the following listed below?
□Contact lenses □ Eyeglasses □ Dentures □ Hearing Devices

Have you ever had permanent makeup? □NO □YES Procedure Type: _____

Where did you have your permanent makeup done?_____

Were you happy with your results? _____

Do you plan or have recently undergone any elective or medically necessary facial or laser procedures? □**NO** □**YES** (If yes, please describe) _____

Are you or do you suspect that you are Pregnant? Are you currently nursing? □**NO** □**YES** (If *yes, how long?)*_____

Please check the box(es) below if you have or had any of the conditions listed. If any of the conditions apply to you, please explain in detail on the line provided.

□Herpes (Type?)_____	□HIV_____	□Autoimmune disorder _____
□Hepatitis (Type?)_____	□Tuberculosis (TB)_____	□Jaundices _____
□Hemophilia_____	□Heart conditions _____	□Keloid former _____
□High Blood Pressure _____	□Blood Disorders _____	□Seizures _____
□Hematoma _____	□Hyper/Hypo Pigmentation _____	
□Mental Illness _____	□Taking Blood Thinners(Aspirin/Steroids) _____	
□Cold Sores _____	□Conjunctivitis _____	□Blepharitis _____
□Bruising _____	□Suffer Dry Eyes _____	□Fever Blisters _____
□Dermatitis _____	□Diabetes _____	□Eye Disorders _____
□Suffer Facial Trauma _____	□Cancer _____	□Glaucoma _____
□ Alopecia _____	□ Asthma _____	□Shingles _____
□Lupus _____	□ Cosmetic Allergies _____	□Oily/Dry Skin _____
□Healing Problems _____	□Chapped Lips _____	□Bleed Easily _____
□Numbing problems _____	□Thyroid _____	□Other(s): _____

Touch Of Beauty Inc. Client Registration Form

Taking Beauty To The Next Level ***Please allow at least 15 minutes to complete this form.**

Client Consent

***Please read carefully and initial after each statement.**

● I understand that I need to stop using using Retin A, Renova or Glycolic Acids at least two weeks prior to all procedures. **Initial** _____

● I understand that I must be off Accutane "Isotretinoin" at least one year before having any procedures. **Initial** _____

● I have been advised by Jennifer Phung, that If I have any autoimmune diseases that I was made fully aware that I would run a greater risk of infection(s) and will have a longer and poor healing outcome. **Initial** _____

● I fully understand that any facial laser treatments, tanning beds, prolonged exposure to the sun, other form of UVA, as well as a person's body chemistry can decrease the degree of color of my permanent makeup. **Initial** _____

● I understand that depending on many factors such as age, health, medication, skin condition, lifestyle and home care before and after the procedure(s) that it may take three to six weeks for the finished result to be "settled in". **Initial** _____

● I have been informed that if I have a history of fever blisters or cold sores that I must take an anti-viral medication orally before and during any lip tattoo procedures. I also have been advised that fever blisters can occur with any lip procedures, 90% of the population has the virus. I understand that I should use Valtrex one week before and one week after the procedure(s). **Initial** _____

● I have received before and after instructions in writing and also verbally. I agree to follow these instructions as written and agree to ask any questions if I am unclear of what needs to be done. **Initial** _____

● I understand that I should not wear any makeup on the day of my procedure. If I wear contact lenses, I must wear my glasses on that day. **Initial** _____

● I understand that a certain amount of discomfort can be experienced during the procedure and that minor and temporary swelling, redness and/or fever blister/cold sores may occur.**Initial** _____

● I have been made fully aware of the fact that permanent makeup can take multiple sessions requiring more than one visit to get the desired results. It has been made clear to me that I must schedule a return visit **at most 60 days** after my procedure(s) for a free touch up, if **after 60 days** I will have to pay **$75.00** for my touch up. **Initial** _____

● I accept that there will be no refunds upon treatment for this elective procedure(s). **Initial** _____

● I understand that hidden scar tissues can saturate or retain color differently than expected and desired color/saturation cannot be guaranteed. **Initial** _____

● I have been advised to withhold donating blood for a least one year following permanent makeup procedure(s). **Initial** _____

● I have been advised to let any skin care and cosmetic professionals and or medical professionals aware of my permanent makeup procedure(s). **Initial** _____

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Client Consent

- I acknowledge that the procedure(s) that I have electively chosen, all involve(s) risk and the possibility of complications during and following the procedure(s). I understand that infections, misplaced pigment, poor color retention, hyperpigmentation, corneal abrasions may occur.

- I have been told not to put any makeup or skin care product on the tattooed area for **10 days**.

- If I elected to have the full lip procedure, I understand that I cannot kiss for **1 week**.

- I have been educated and have had the opportunity to ask questions on the proposed permanent makeup procedure along with it's risk to my satisfaction.

- I have been told about **Touch of Beauty's Referral Program** which offers Touch of Beauty alumni clients to a **Free Enhancement** for every two clients who had been referred, and had the procedure with Touch of Beauty. If I refer a minimum of five clients to Jennifer, I would receive 30% off of my next procedure.

Office Use Only

Touch of Beauty's Referral Program

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

By Signing below you:

- **Have read all four pages of this Client Registration Form and understand it's content.**

- **Have consented Jennifer Phung to perform your procedure(s).**

- **Have agreed that all information given on this form is true to the best of your knowledge.**

_____ _____

Signature of Patient or Personal Representative **Date**

*If Personal Representative signs, please give their name(Print) and describe their relationship to the patient below.