**CLIENT INFORMATION SHEET**

NAME Date of Birth:

ADDRESS

PHONE (Day) Night

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

PROCEDURES DESIRED:

 Eyeliner Eyebrows Lip line Full Lip Color Nipples

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 lip line or full lip color procedures.

\*Signed: (Client)

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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: