

JS Esthetic Studio
1056 West Jericho Tpk. Smithtown, NY 11725
516-449-1234
www.JSEsthetics.com

Today's Date ____/____/____

Name _____ Date of Birth ____/____/____ Email: _____

Ethnic Background, please include all nationalities _____

Address _____ Apt. # _____ City: _____

State _____ Zip _____ Home Phone (____) _____ Cell (____) _____

Occupation: _____

Emergency Contact, Name _____ Phone
(____) _____ Relationship _____

Who may we thank for referring you? _____

Procedure(s) desired: Brows Eyeliner Lips Camouflage Areola Complex Correction

List all medications you are presently taking

Name of drug	Mg. or mcg.	How many ea. day	Why it was prescribed to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all medications you took in the last six months that you are no longer taking:

Name of drug	Mg. or mcg.	How many ea. day	Why it was prescribed to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Practitioner Signature _____ **Date** ____/____/____

Do you have? (check all that apply)

- Fever Blisters/Cold Sores (Ever, even one time)**
- Glaucoma or other eye disease/disorder
- Grave's Disease
- Heart Disease
- Mitral Valve Prolapse
- Valve Implants
- Pacemaker
- Stents
- Diabetes requiring insulin
- Problems with healing
- Keloids
- Seizures
- Dermatological Disorder
If so, what? _____
Active or in Flare-ups? _____
- Hemophilia or Clotting Disorder
- Autoimmune Disorder
- Pre-existing nerve damage
- Tattoos
Colors you are sun sensitive to: _____

- Trichotillomania (pulling of hair, brows, lashes)
- Alopecia Totalis or Areata
- Allergies
List: _____

Are you? (check all that apply)

- Pregnant
- Planning cosmetic surgery
If so, what & when? _____
- Currently under the care of a physician
Describe _____

Do you practice outdoor activities? Circle all that apply

- | | |
|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Tennis | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Golf | <input type="checkbox"/> Skiing |
| <input type="checkbox"/> Gardening | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Boating | <input type="checkbox"/> Other |

Do you use? (check all that apply)

- Accutane (currently or within the past year)
- Antibiotics prior to dental procedures
- Steroids
- Retin-A, Glycolic Acid, Vitamin C or other Exfoliants
- Tanning Beds
- Eyebrow Tinting
- Eyelash Tinting
- Latisse
- Botox When _____
- Chemical Peels When _____
- Chemotherapy or Prophylactic dose of Chemotherapy
- Blood Thinners

Have you had? (check all that apply)

- Fever Blisters/Cold Sores (Ever, even one time)**
- Eye Infections (Are you prone to them)
- Vision Correction Procedure (Lasik, RK) within the past 3 months
- Heart Attack - When? _____
- Joint Replacement, Organ Transplant
- Eye Trauma
- Seizures
- Fainting Spells
- Hepatitis - What Type: _____
- Hepatitis Test - When? _____
- Fat Transfer Injections - If yes, where? _____
- Gore-Tex Implants - If yes, where? _____
- Aesthetic or Cosmetic Procedures
If yes, where? _____
- Laser Treatments
- What type & why? _____

Physician's Name: _____
 Address: _____
 Phone: _____
 Specialty: _____

Signature of Practitioner _____ Date ____/____/____
 Client Name _____

INFORMED CONSENT TO PROCEDURE

JS Esthetics Studio , 1056 West Jericho Tpk, Smithtown, NY 11725

1. I absolutely understand and accept that such procedure is a process, often requiring multiple applications of color to achieve desirable results and the 100% success cannot be guaranteed.

2. Depending on the procedure(s), which I select, I accept responsibility for determining the shape, and position of eyebrows, eyeliners, lip liner and/or full lip color.

3. I understand that the color selection and color results in all procedures are not an exact science.

4. I understand that positioning of my procedures can be affected if I have elected or wish to elect cosmetic surgery, Botox or Restalyne and I assume this responsibility.

5. I am aware that if I am to receive an MRI after the procedure, I must tell the Radiologist that I have iron oxide permanent cosmetics.

6. If I am a lens wearer, I realize that I must keep my lenses out the day of an eyeliner procedure.

7. I understand that this procedure will fade and this fading can alter the original pigment color and that this determines that it is a time for a touch-up visit.

8. I realize this is an elective cosmetic procedure and is not medically necessary.

9. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment.

10. I understand that many lasers & IPL's (Intense Pulse Lights) including those used for hair removal, anti-aging, Photo Facials, removal of lines may or will turn permanent make up dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent make up.

11. I give my consent to **Insert Name Here** to confer with my physicians for medical information required for the safety of my procedures.

12. I agree to accompany my practitioner to the emergency room in the event they were to be accidentally stuck with my needle and take a blood test for their safety & disclose all test results to my practitioner.

13. I am aware that if an infection occurs after I have received Permanent Cosmetics to see with my primary physician or an emergency room, *immediately*.

14. If I had permanent cosmetics performed previously by another practitioner, I do not hold **Judith scavarelli/JS Esthetics** responsible for future allergic reactions or contraindications.

ACCEPTANCE:

I have read and understand these risks listed above and they have been explained to me. **I DID NOT JUST SIGN THIS DOCUMENT.** I certify that the information in the above questionnaire is accurate and my questions have been answered. I accept full responsibility for any complications that may arise or result during or following the cosmetic procedure(s) to be performed at my request.

Signature of Client X _____.

Date ____/____/____

Signature of Practitioner _____.

Date ____/____/____

