Divine
Lashes & More

Downtown Naples FL - Radio Rd Naples FL & Fort Myers FL
239-777-4113 / 239-331-9941

# LIP BLUSH TATTOO INTAKE & CONSENT FORM

## PERSONAL INFORMATION

Name: _____ DOB: _____/_____/_____ Date of Consult: _____/_____/_____
Address: _____
City: _____ State: _____ Zip: _____ Phone Number: _____
Email Address: _____ Gender: ☐ M ☐ F ☐ O

How did you hear about us? ☐ Facebook ☐ Instagram ☐ Other _____

## MEDICAL HISTORY

| | | |
|---|---|---|
| Are you currently taking any medications? | ☐ Yes | ☐ No |
| Do you have any allergies? | ☐ Yes | ☐ No |
| Are you currently pregnant or nursing? | ☐ Yes | ☐ No |
| Are you or have you been on Accutane within the past 6 months? | ☐ Yes | ☐ No |
| Have you used Retin-A, Renova, AHA or Retinol derivative products within the past 5 days? | ☐ Yes | ☐ No |

Please list any Surgeries, including plastic surgery

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## CONTRAINDICATIONS

Although it is impossible to list every potential risk and complication, the following conditions are recognized as contraindications for Cosmetic Lip Tattoo treatment and must be disclosed prior to treatment. If one or more than one apply, the procedure should NOT be performed.

Do any of the following apply to you? Please check all that apply.

- ☐ Active Acne
- ☐ Hemophilia
- ☐ Do you have any bacterial or viral infection?
- ☐ Hormonal Therapy that produces thick Pigmentation
- ☐ Allergies to topical anesthetic ingredients, needles or permanent makeup pigments?
- ☐ Recent Chemical Peels
- ☐ Blood Thinner Medications
- ☐ Chemotherapy or Radiation
- ☐ Eczema or Dermatitis
- ☐ Hypertrophic scars, keloids, hyperpigmentation or hypopigmentation.
- ☐ Rosacea
- ☐ Scleroderma
- ☐ Skin Cancer
- ☐ Botox or Cosmetic Filler Injections within 2 weeks
- ☐ Facial waxing (not within past 14 days)
- ☐ Uncontrolled Diabetes
- ☐ IPL/Laser Therapy (not within past 14 days)
- ☐ Skin Disease/Skin Lesions
- ☐ Do you currently have open wounds?
- ☐ Convulsions or fainting.
- ☐ Transmissible blood diseases: autoimmune disorders or hepatitis.
- ☐ Moles
- ☐ Sunburn
- ☐ Facial Tattoos
- ☐ Recent use of topical agents such as Glycolic Acids, AHA and Retin-A
- ☐ Family History of Hypertrophic scarring or Keloid
- ☐ Telangiectasia/Erythema may be worsened or brought out by exfoliation
- ☐ Vascular Lesions
- ☐ Undiagnosed active skin diseases: psoriasis, eczema or rashes.

Other

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Please read ALL of the following statements carefully and indicate your understanding and acceptance

| | |
|---|---|
| | I hereby declare that I have been informed, in detail, about the PMU Lip Blush method and procedure which will be performed. I was informed that needles are used for the treatment to inject color pigments into the upper layers of the skin. |
| | I am aware that it is not possible to predict how durable and intensive the lip color will be and that durability and color intensity depend on age, skin type, and environmental conditions of the treated person. I am aware that the treatment with the pigmenting needles can cause skin irritation and minor inflammation of the skin which usually disappears within 24-36 hours. If predisposed to cold sores, start taking medication immediately, as trauma to the lip can cause an outbreak and may affect pigment retention. |
| | I have been informed that the pigments will appear darker within the first few days immediately following the procedure than the final result. It will be necessary to undergo a follow up treatment. I have been informed of the section of skin to be pigmented may be anesthetized/numbed with a surface anesthetic. |
| | I have been informed that medicines affect different individuals in different ways. Just because side effects have occurred in some cases, it does not mean they will occur to me. Some common side effects anesthetics may include: Allergic reaction, light headedness, drowsiness/dizziness, vomiting, numbness of the tongue, unusually slow heartbeat. |
| | Although topical anesthesia is applied at the beginning of the procedure, pain may be experienced, depending on the pain threshold of each person, but whenever necessary anesthesia will be applied again to numb the area again. |
| | I have informed my practitioner of any medication I am currently taking, which may affect blood coagulation during the Lip Blush procedure. |
| | I authorize the use of my photographs taken by Skin Aesthetics Clinique to be used on social media and shown to potential clients. |
| | Furthermore, I state that:<br>• I am not diabetic<br>• I am not hemophiliac<br>• I do not test positive for the HIV or Hepatitis Viruses<br>• I am not pregnant |
| | I hereby declare that I am not intoxicated and that I am fully aware of the treatment procedure and that I understand the above statement to be true. I give my consent to have PMU: Lip Blush performed and assume full responsibility for the outcome. I do not and will not hold DIVINE LASHES & MORE or the technician responsible or liable should the result may not be as discussed or as I had imagined. |

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Please read ALL of the following statements carefully and indicate your understanding and acceptance

| | |
|---|---|
| | I understand that this treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume those risks. |
| | I understand that if I am not willing to accept all risks associated with this procedure then I should not have the Lip Blush Treatment. |
| | I certify that all my questions have been addressed and answered to my satisfaction, that I have read this entire consent, and that I understand and agree to the information herein. |
| | I understand that to receive Lip Blush Treatment at DIVINE LASHES & MORE I must comply with all stipulations outlined in this consent form; if I do not agree then I will not be able to proceed with treatment. |
| | I freely and voluntarily accept all risks associated with Lip Blush Treatment and elect to proceed with treatment today as well as future and ongoing treatments. |
| | I have read the contents of this consent form carefully and I fully understand it. I have been given the opportunity for discussion pertaining to the treatment and all my questions have been answered to my satisfaction. |
| | I hereby release DIVINE LASHES & MORE and any of its employees from any and all liability associated with this procedure if I do not fully comply with all pre and post care of this procedure. |
| | I have been adequately informed of the risks and benefits of this treatment and wish to proceed with the treatment. |
| | If I have a history of herpes, fever blisters and cold sores, I may experience an outbreak after the procedures and I am aware that I must have the medications prescribed by my doctor in case of herpes activation. |
| | I affirm that I have received instructions regarding aftercare and that failure to follow the instructions may lead to an unexpected result and possible situations that alter the recovery process. |

**BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT AND ALL THE INFORMATION DETAILED ABOVE**

| CLIENT | PRACTITIONER |
|---|---|
| Name: _____ | Name: _____ |
| Signature: _____ | Signature: _____ |
| Date: _____ | Date: _____ |