



1990 Route 70 Cherry Hill, NJ • 856-727-1411 • beauintstitute.com

Today's Date ____/____/____

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

Ethnic Background, please include all nationalities _____

Address _____ Apt. # _____ City: _____

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

Occupation: _____ If we call you at home, do you want confidentiality? ☐ No ☐ Yes

May we call you at work? ☐ No ☐ Yes If Yes, my work number is (____) _____

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 a 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

☐ Shingles History/Recent Shingles Shot

☐ 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

Tennis
Golf

Swimming
Skiing

Boating
Gardening

Walking
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 ____/____/____

INFORMED CONSENT TO PROCEDURE

1. Are you pregnant or nursing?

Yes ☐ No ☐

Initial

2. 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. _____

3. I have received, reviewed and understand the pre-procedural instructions as given to me and agree to follow them. _____

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

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

6. 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. _____

7. 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. _____

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

9. 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. _____

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

11. I have pre-medicated where indicated, prior to my procedure. _____

12. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling. _____

13. Although rare, Fever blisters may occur regardless of pre-medication. _____

14. 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. _____

15. I give my consent to Beau Institute to confer with my physicians for medical information required for the safety of my procedures. _____

16. 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. _____

17. 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**. _____

ACCEPTANCE:

I have read and understand these risks listed above and they have been explained to me. I certify that the information in the above questionnaire is accurate and my questions have been answered.

*****Please read all questions thoroughly before signing!!***

Client Name (Print) _____ Signature of Client X _____

Signature of Practitioner _____ Date ____/____/____