Erin Meier, CMM
Permanently Perfect Cosmetics, LLC/Erin Meier Aesthetics
Under Supervision of Dr. Ivan Wayne: W Facial Aesthetics

Medical Micropigmentation Medical History Form

Name:			Date:
Date of Birth:	Age:	Male / Female	Marital Status:
Address:		Cell Phone: May we leave a Message? Yes / No	
		Home Phone: May we leave a Message? Yes / No	
Email Address:		Referred By:	
Emergency Contact:		Emergency Contact Number:	
Physicians Name:		Physicians Number:	
Employer:		Job Title:	

Please Answer the Following Questions	**YES**	**NO**
1. Are you under medical treatment now?		
2. Have you ever been hospitalized for any reason within the last 5 years? If yes, please explain:		
3. Are you currently taking any medications including non-prescription medicine? If yes, please explain:		
4. ADHD/Psychological Disorders?		
5. Are you allergic to or have you had any reactions to the following? A) Local Anesthetics (ex. Novocain) B) Penicillin or any other Antibiotics C) Sulfa Drugs D) Barbiturates E) Sedatives F) Iodine G) Aspirin H) Any Metals (ex. Nickel, Mercury, etc.) I) Latex Rubber J) Other (Please List)		
6. Are you currently taking Retin A, Glycolic Acid, Acutane?		
7. Any Drug, Makeup, Skin or Food Allergies (ex. Soaps or Cleansing Creams)		
8. Have you been sick or had flu like symptoms in the past 3 weeks or have a disease that weakens your immune system?		
8. Women Only: A) Are you pregnant or think you may be pregnant? B) Are you taking oral contraceptives?		

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Please Answer the Following:	**YES**	**NO**	**Please Answer the Following:**	**YES**	**NO**
High Blood Pressure			Fever Blister/Cold Sores		
Low Blood Pressure			Herpes Simplex		
Heart Attack, Disease, or Murmur			Diabetes		
Abnormal EKG			Liver Disease		
Rheumatic Fever			Hepatitis		
Scarlet Fever			Thyroid Disease		
Angina/Chest Pain			Neck/Back Injury/Problems		
Stroke			Joint Replacement		
Asthma			Blepharoplasty (Eyelid Surgery)		
Emphysema/Lung Disease			Eye Surgery (Including RK/PRK Lasik)		
Fainting Spells/Disease			Eye Injury		
Anemia/Sickle Cell Trait/Disease			Dry Eyes		
Blood Transfusion			Corneal Abrasion		
Bleeding Tendency/Prolonged			Glaucoma/Cataracts		
Porphyria (Blood Disease)			Epilepsy/Seizures		
Cancer			Emotional/Psychiatric Illness		
Tumor/Growth/Cyst			Hyper pigmented Scars		
Chemotherapy/Radiation			Keloid Scars		
Hemophilia			Facial Plastic Surgery		
Do you use Tobacco Products?			Are you wearing Contact Lenses?		
Do you use Controlled Substances?			Are you currently taking Aspirin or Ibuprofen?		
Are you using any Eye Drops or other Ocular Medications?			Have you recently undergone a skin peel?		
			Are you currently using Latisse?		

I hereby certify that the information listed above which I have provided regarding the medical history and status thereof is completely true and correct and may be relied upon for all purposes by Erin Meier and W Facial Aesthetics, any assistants, colleagues, staff, employees and any other people treating or assisting in the above named patient.

SIGNATURE: _____DATE:_____

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Disclosure and Consent for Medical Micropigmentation Procedures

I, _____, as a client have requested that you describe the procedure to be utilized so that I may make an informed decision whether or not to undergo the procedure.

You have described the recommended procedure to be used as Micro Pigment Implantation, the process of implanting micro insertions of pigment into the dermal layer of skin. Micro Pigment Implantation is a form of tattooing used for the purpose of permanent cosmetic makeup and skin imperfection camouflage.

I voluntarily request, the permanent make-up technician, Erin Meier, and such association and technical assistance, to perform on my body the following procedure: (**CIRCLE ONE**)

EYELINER EYEBROWS LIP LINER FULL LIP COLOR

UPPER EYELINER ONLY EYE LASH ENHANCEMENT LOWER MUCOSAL EYELID

SCAR CAMOUFLAGE

Please Read and Initial:

_____ I hereby authorize to take photographs of the work performed both before and after treatment, and I further authorize the use of said photographs to be used for the purpose of advertising.

_____ I hereby authorize Erin Meier to take photographs of the work performed both before and after treatment to be maintained only in file.

_____ I have informed Erin Meier that I am in good health and I am not under the care of any physician.

_____ I am currently under the care of a physician and I am being treated for the following condition(s):

_____

_____

Physician's Name: _____

Physician's Specialty: _____

Address: _____

Phone: _____

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Please Read and Initial:

_____ I have been told that allergic reactions to pigment are very rare, however, they can and do occur and when they do occur they can be serious and especially difficult and very troublesome to treat.

_____ Other risks involved with the procedure may include, but not limited to: infections, allergic and other reaction(s) to applied pigments, allergic and other reaction(s) to products applied during and after the procedure that are planned for me.

_____ I have been told this procedure will involve pain, discomfort, and bruising.

_____ I understand that the markings are permanent and there is a possibility of hyper pigmentation resulting from a procedure, especially in individuals prone to hyper pigmentation from a scar of other injury. There is a risk of infection following the procedure.

_____ I understand that there is a possibility of migration of the pigment (ink) to skin around the procedure site.

_____ I have been told that a follow up procedure may be required within 60-90 days of the initial treatment to be covered (included) in the cost. If the allowed touch-up time frame has lapsed, the procedure can be performed for a fee of $175. After the second cancellation\reschedule of a 60-90 touchup, the (included) touchup becomes void.

_____ If a third application is needed, I understand a spot treatment or an additional touchup may be needed to achieve the desired outcome. I understand this is an additional charge and not included in the initial or touchup application. This additional charge is at a discounted rate that covers the supplies, products, and anesthetic that is used during the spot treatment/additional touchup application.

_____ I am aware the color of the pigment may fade or even change colors over time. Color refresh applications are recommended every 2-6 years to refresh your permanent cosmetics and ensure longevity. Some applications may require yearly refresh applications.

_____ I have been told there is a chance that I may experience a corneal abrasion from the eyeliner procedure.

_____ I accept full responsibility for any and all, present and future, medical treatment(s) and expenses I may incur in the event I need to seek treatment(s) for any known or unknown reason associated with the procedure planned for me.

_____ I have been given an opportunity to ask questions about the procedures and the procedure to be used and the risks and hazards involved and I believe that I have sufficient information to give the informed consent.

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_____ I am currently unaware of any reaction I may have to Bacitracin, Neosporin, Mycitracin, Bactroban or Vaseline.

_____ I understand that if I have an infection, adverse reaction, or allergic reaction to the procedure, I must notify Erin Meier, the Medical Micropigmentologist.

_____ I have agreed that should I have a complaint of any kind, whatsoever, I shall immediately notify Erin Meier and I further agree that any controversy or claim arising out of or relating to this consent and/or any signed contract between myself and or the breach thereof, shall be settled by arbitration in the state of Oklahoma in accordance with the Rules on the American Arbitration Association and judgment of the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

_____ I certify this form has been fully explained to me and I have read it or it has been read to me. I understand its contents.

_____ I have received a copy of the Post Procedure Instructions. It has been fully explained to me, and I have read it or it has been read to me. I understand its contents.

_____ I understand that I must have a driver if I have taken pain medication, muscle relaxers, anti-depressants/anxiety medication, Benadryl or any other medication that could affect my driving ability.

_____ I have been told that there may be known and unknown hazards related to the performance of the procedure planned for me and I understand that no warranty or guarantees have been made to me as to the results.

_____ I understand this description of the procedure is not meant to scare or alarm me. It is simply an effort to make me better informed so that I may give or withhold my consent for this procedure.

_____ I acknowledge the manufacturer of the pigment to be applied requires spot testing and specifically disclaims any responsibility for any adverse reaction to applied pigments. I understand spot testing may identify individuals who develop an immediate reaction to pigment; however, spot testing does not identify individuals who may have a delayed allergic to pigment.

I agree **(CIRCLE ONE): RECEIVE/WAIVE** a spot test prior to application and I agree to release Erin Meier, assistants and pigment manufacturer(s) from any and all liability related to allergic reaction or any other reaction to applied pigments.

SIGNATURE_____DATE_____

PPC LLC WITNESS_____DATE_____