Refine Aesthetics

CLIENT INFORMATION/MEDICAL HISTORY

Name _____Age_____ Date_____

Address_____City_____State_____Zip_____

Email Address_____

Cell_____ Date of Birth_____

Emergency Contact_____Relationship_____Cell_____

Medications (Prescriptions/over the counter med, vitamins, herbal medications)

_____

_____

Drug Allergies_____

Major Surgeries/Facial surgeries_____

Ongoing facial treatments? (Injectibles/Laser/chemical peels/waxing/facials)_____

Please circle if you have any of the following conditions –

Heart Disease Excessive Bleeding High Blood Pressure Hepatitis Skin Cancer Liver Disease

Lupus Auto-Immune Disorders Diabetes Neuromuscular Disease Cold Sores/Fever Blisters

Lidocaine allergy/sensitivity

Pregnant? Y N Breastfeeding? Y N

The above information is true and accurate to the best of my knowledge.

_____

_____ _____

Client Signature **Date**

Refine Aesthetics

Use of Photographs for Before/After Comparison

Explanation –

This consent form authorizes Refine Aesthetics to use these photographs for before and after comparison after treatment. Under no such circumstances will any publications or material bear your name. Your refusal to consent to the use of these photographs for before/after comparison will in no way influence your treatment.

Consent –

I understand the photographs taken of me shall be used for my medical records showing before/after comparison. If in the judgement of the medical health care professional they would benefit in educating others who are seeking the same treatment, I give my consent for Refine Aesthetics to publish said photos. All photos will only show area treated.

I waive the rights that I may have to any claims for payment or royalties in connection with any exhibition, televising or publication of these photographs.

I release and hold harmless Refine Aesthetics, the staff and consultants from any liability in connection with the use of such materials.

I understand that this consent is subject to the following limitation – Under no circumstances will any such publication, film photograph, video tape or material exhibited contain my name unless voluntarily disclosed by me.

_____ _____

Signature of Client **Date**

EYELASH LIFT & TINT

CONSENT FORM

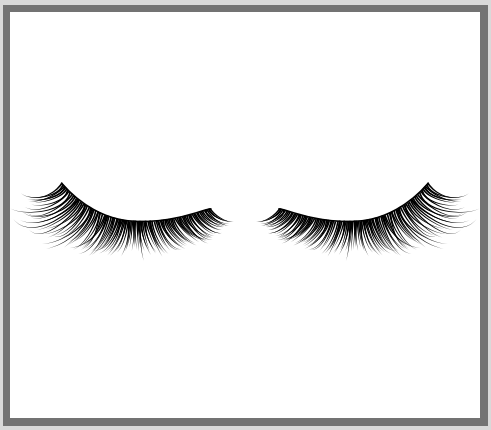
Name _____

DOB _____ Phone _____

Address _____

_____

Email _____



Medical History

- ☐ Dry Eyes
- ☐ Permanent Cosmetics
- ☐ Blepharoplasty
- ☐ Seasonal Allergies
- ☐ Alopecia
- ☐ Recent Fever
- ☐ Skin Disease
- ☐ Diabetes
- ☐ Retinoids, Accutane
- ☐ Pregnant/Recent Childbirth
- ☐ Hormone Imbalance
- ☐ Current use of eye drops
- ☐ Wear Contact Lenses
- ☐ Immune Disorders
- ☐ Anxiety
- ☐ Radiation/Chemotherapy

Recent Surgery _____

Other _____

By signing below, you agree to the following:

I understand that results will vary between individuals and no guarantees have been made regarding my personal results. I agree to have photographs taken before and after to document the original condition of my natural lashes.

I understand that my results may be compromised if I do not follow the aftercare instructions that I have been given.

I have been informed of and understand the contraindications to the requested treatments and agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment.

The procedure and side effects have been explained to me and I have had the opportunity to ask questions. My questions have been answered in a satisfactory manner.

I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred. I accept all risk and liability for this cosmetic procedure. This consent form is valid for future treatments until it is rescinded by me in writing.

_____

Client Signature (Guardian if under 18)

Date _____

Have you ever had an allergic reaction to any of the following?

- ☐ Food
- ☐ Cosmetics
- ☐ Glycerine
- ☐ Synthetics
- ☐ Medicine
- ☐ Adhesives
- ☐ Latex
- ☐ Hair Color

Other _____

_____

Have you had an Eyelash Lift or Tint before?

- ☐ Yes
- ☐ No

Do you use Waterproof mascara?

- ☐ Yes
- ☐ No

I understand that the following are potential side effects:

- Eye Irritation
- Hair Damage
- Burning
- Itching
- Pain
- Allergy
- Swelling
- Inflamation
- Eye Infection
- Redness
- Potential Blindness
- Temporary Skin Staining

Current Medications:

_____

_____

_____

_____