CONSENT TO TATTOO PROCEDURE

NAME: DATE:

DATE OF BIRTH: LICENSE #

ADDRESS: CITY:

STATE: ZIP: PHONE#

I acknowledge by signing this agreement that I have been given the full opportunity to ask any and all questions which I might have about the obtaining of a tattoo and that of my questions have been answered to my full satisfaction. I specifically acknowledge i have been advised of the facts and the matters set forth below and agree as follows:

- If I have any condition that might affect the healing of this tattoo, I will advise my tattooer. I am not pregnant or nursing. I am not under the influence of alcohol or drugs.

- I do not have medical or skin conditions such as but not limited to: acne, scarring (Keloid) eczema, psoriasis, freckles, moles or sunburn in the area to be tattooed that may interfere with said tattoo. If I have any type of infection or rash anywhere on my body, I will advise my tattooer.

- I acknowledge it is not reasonably possible for the representatives and employees of this tattoo shop to determine whether i might have an allergic reaction to the pigments or processes used in my tattoo, and agree to accept the risk that such a reaction is possible.

- I acknowledge that infection is always possible as a result of a tattoo, particularly in the event that I do not take proper care of my tattoo. I have received aftercare instructions and i agree to follow them while my tattoo is healing. I agree that any touch-up work needed, due to my own negligence, will be done at my own expense.

- I realize that variations in color and design may exist between any tattoo as selected by me and as ultimately applied to my body. I understand that if my skin color is dark, the colors will not appear as bright as they do on light skin.

- I understand that if i have any skin treatments, laser hair removal, plastic surgery or other skin altering procedures, it may result in adverse changes to my tattoo.

- I acknowledge that a tattoo is a permanent change to my appearance and that no representations have been made to me as to the ability to later change or remove my tattoo. To my knowledge, I do Not have a physical, mental or medical impairment or disability which might affect my well being as A direct or indirect result of my decision to have a tattoo.

- I acknowledge i am over the age of eighteen and that i have truthfully represented to my tattooer that the obtaining of a tattoo is by my choice alone. I consent to the application of the tattoo and to any actions or conduct of the representatives and employees of the tattoo shop reasonably necessary to perform the procedure.

Client signature: Date

Tattooer signature: Date

PRE-EXISTING CONDITIONS WHICH MAY AFFECT
YOUR SUITABILITY FOR THE DESIRED PROCEDURE(S)

To help minimize any risks, which might be a part of the procedure(s), the Client should answer the following questions truthfully and to the best of their ability, in order to assist the Specialist in ensuring that the Client is a suitable candidate for the procedure(s) requested. The Client acknowledges that any incomplete or inaccurate answers given to these questions may increase the possibility of complications and unwanted results from the procedure(s), and, as such, confirms that the answers given are true and accurate.

In the event that additional space is required, use the back of this form or additional paper; if the explanation is difficult to write briefly or concisely, please discuss it directly with the Specialist.

If your answer is **Yes** on any item, please provide explanation, including dates, durations, frequencies and circumstances as required:

Yes___No___ Are you pregnant or nursing ____

Yes___No___ Are you allergic to any medications ____

Yes___No___ Are you allergic to Latex, Glycerin, Rubber or PABA ______________________________

Yes___No___ Are you allergic to topical anesthetics (lidocain, novocain, epinephrine, etc.) ____________________

Yes___No___ Are you allergic to topical salves (bacitracin, neomyacin, Neosporin, etc.) ____________________

Yes___No___ Are you diabetic ____

Yes___No___ Do you have any type of heart condition ____

Yes___No___ Do you have a mitral or prolapsed heart valve ____

Yes___No___ Do you have any joint replacements ____

Yes___No___ Are you required to take an antibiotic before seeing a dentist ______________________________

Yes___No___ Do you have any type of blood disease ____

Yes___No___ Are you hemophiliac ____

Yes___No___ Do you have / have you had any form of hepatitis ______________________________

Yes___No___ Are you on blood thinners (including aspirin, ibuprofen, coumadin, etc.) ____________________

Yes___No___ Do you have an auto immune disorder ____

Yes___No___ Do you suffer from alcoholism ____

Yes___No___ Are you epileptic or subject to seizures ____

Yes___No___ Do you have glaucoma ____

Yes___No___ Do you have any dermatological disorders (eczema, rosacea, psoriasis, dermatitis, shingles, etc.) __________

Yes___No___ Do you have herpes ____

Yes___No___ Do you have (or are you prone to) cold sores ____

Yes___No___ Do you have (or are you prone to) keloid formation ______________________________

Yes___No___ Do you have trichotillomania ____

Yes___No___ Do you have alopecia ____

Yes___No___ Do you use cortisone ____

Yes___No___ Do you use glycolic acid ____

Yes___No___ Do you use acutane ____

Yes___No___ Do you use Retin-A ____

Yes___No___ Have you used chemical peels ____

Yes___No___ Do you use steroids ____

Yes___No___ Do you have/ have you had any form of cancer ____

Yes___No___ Are you undergoing chemotherapy ____

Yes___No___ Are you currently taking any medications (please list) ____

Yes___No___ Have you had any surgeries in the past 12 months ____

Yes___No___ Are you currently under a doctor's care for any particular condition _______________________________

Yes___No___ Do you have Tourette's syndrome or are you prone to nervous tics ___________________________________

Yes___No___ Do you have any other disease not already mentioned ____

Yes___No___ Are you planning to have any cosmetic surgery ____

Yes___No___ Do you have other tattoos ____

Yes___No___ Do you tan (tanning beds, lamp, or natural light) ____

Yes___No___ Have you had brow or lash tinting ____

Yes___No___ Do you wear contact lenses (if so, please be sure to remove them prior to your procedure)

Yes___No___ Are you under 18 years of age? **If yes, you must have the written legal consent of your parent or guardian on file with the Specialist before your procedure. Signature of parent or guardian ____**

Yes___ No___ Within the past year have you had any infectious or communicable diseases such as, but not necessarily or limited to, jaundice or hepatitis as well as any condition that might affect the procedure or healing process such as lupus, diabetes or hemophilia.

Dated this _____ day of _________________, 20____.

Client name (printed)____

Client signature____