A Nu Reflection

5050 Rt. 42 Turnersville, NJ 08012

Today's Practitioner _____ **Today's Date** _____/_____/_____

**** I am aware of the current COVID -19 Pandemic and acknowledge that there is a risk, however slight, by consenting to having a body art procedure performed and agree to assume that risk.**

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

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 ☐ Areola ☐ Correction ☐ Lightening

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 <u>in the last six months</u> that you are no longer taking:

Name of drug	**Mg. or mcg.**	**How many ea. day**	**Why it was prescribed to you**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Client Signature _____ **Date** _____/_____/_____

Practitioner Signature _____ **Date** _____/_____/_____

Dr. Signature _____ **Date** _____/_____/_____
(if required)

GENERAL MEDICAL Client Name: _____

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
- ☐ 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	Swimming
Golf	Skiing
Gardening	Walking
Boating	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 _____/____/_____

Signature of Dr. (if required) _____ Date _____/____/_____

INFORMED CONSENT TO PROCEDURE

POCEDURE TYPE: _____ DATE_____

Some Potential reactions following procedure: scabbing, flaking, pigment loss, infection (if not properly cared for), swelling, itching, redness

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. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, scabbing, bruising, redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment. _____

12. 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. _____

13. I give my consent to **A NuReflection, LLC** to confer with my physicians for medical information required for the safety of my procedures. _____

14. 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. _____

15. 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***. _____

16. I am aware of the current COVID -19 Pandemic and acknowledge that there is a risk, however slight, by consenting to having a body art procedure performed and agree to assume that risk. _____

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.

I acknowledge due to the current state of events with COVID -19 I am more susceptible

Please read all questions thoroughly before signing!!

Signature of Client _____

Signature of Practitioner _____**Date** _____/_____/_____

Signature of Dr. (if required) _____**Date** _____/_____/_____

A Nu Reflection

5050 Rt. 42 Turnersville, NJ 08012

Photograph and Publicity Release Form

I, _____, give my permission to use my likeness, image, and/or appearance as such may be embodied in any pictures, photos, video recordings, digital images, and the like, taken or made on behalf of A NuReflection, LLC. I agree that A NuReflection, LLC has complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with the A NuReflection, LLC mission. These uses include, but are not limited to illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials in any medium now known or later developed, including the Internet. I acknowledge that I will not receive any compensation, etc. for the use of such pictures, etc., and hereby release A NuReflection, LLC and its agents and assigns from any and all claims which arise out of or are in any way connected with such use.

I have read and understood this consent and release.

I give my consent to A NuReflection, LLC to use my likeness to promote the company, and/or their activities.

___ DO NOT USE FULL FACE

_____ _____

Signature Date

_____

Print Name

A Nu Reflection

5050 Rt. 42 Turnersville, NJ 08012

SHAPE / COLOR REQUEST FROM CLIENT

I _____ am electing to choose my own color and/or shape for my _____ procedure.

My Technician has explained the pros and cons of me choosing my own design and/or color. I am aware that the visual outcome regarding design/shape and/or color is based by my choices

_____ _____

Signature Date

_____

Print Name