Creative Scalp Ink - CLIENT INFORMATION SHEET

NAME: _____ DOB:____/____/_____

ADDRESS:_____

EMAIL: _____ MOBILE PHONE: _____

PROCEDURE(S) DESIRED:

- ☐ Scalp Micropigmentation
- ☐ Other _____

REFERRAL CONTACT, if applicable :_____

Are you currently under the care of a physician?

☐ YES ☐ NO

If so, why? _____ Physician's name: _____

Do you take antibiotics when going to the dentist?

☐ YES ☐ NO

If so, why? _____

Do you suffer from:

- ☐ Allergies
- ☐ Moles or freckles at site of tattoo
- ☐ Hepatitis
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Diabetes
- ☐ Skin Problems
- ☐ Scarring (Keloids)
- ☐ Eye Problems
- ☐ Epilepsy
- ☐ Other: _____

Are you presently taking any medication which thins the blood?

☐ YES ☐ NO

Are you taking other medications?

☐ YES ☐ NO

If so, why? _____

Are you pregnant or nursing?

☐ YES ☐ NO

I understand that if I fail to cancel my appointment within 24 hours, **there will be a charge of $300.**

*Signed: _____(Client) Date: _____