Tel: New York (212) 518-3754
Tel: Houston (281) 898-8744
W: beautygenesis.com
W: browdesign.com
W: skingenesispro.com

Email: info@beautygenesis.com
Youtube: juliannamilinbeauty
IG: @ julianna.milin
Fb: juliannamilinbeauty

BEAUTY GENESIS

3 Grogans Park Drive, Suite 130
The Woodlands, TX 77380 (281) 898-8744

Today's Date: ___/___/20___ Client Info:

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

Ethnic Background (Please include all nationalities): _____

Address: _____ Apt. #: ____ Home Phone: (____) ____-_____

City: _____ State: ____ Zip Code: _____ Cell Phone: (____) ____-_____

Occupation: _____

If we call you at home, do you want confidentiality? ☐ Yes ☐ No

May we call you at work? ☐ Yes ☐ No If *yes*, my work number is (____) ____-_____

Emergency Contact Information:

Name:_____ Phone: (____)____-_____ Relationship: _____

Who may we thank for referring you? _____

Procedure(s) desired: ☐ Brows ☐ Eyeliner ☐ Lips ☐ Camouflage ☐ Areola Complex ☐ Correction

List all medications you are presently taking

Name of Drug	mg or mcg	Amount/Day	Why it was prescribed to you?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all medications you took in the last six months that you are no longer taking

Name of Drug	mg or mcg	Amount/Day	Why it was prescribed to you?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Practitioner Signature: _____ Date: ___/___/20 ___

JULIANNA MILIN

BEAUTY GENESIS

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
- ☐ Shingles History/Recent Shingles Shot
- ☐ 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?

☐ Tennis	☐ Skiing	☐ Boating
☐ Swimming	☐ Gardening	☐ Other:
☐ Golf	☐ Walking	_____

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

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BEAUTY GENESIS

GENERAL MEDICAL

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: ___/___/20___

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BEAUTY GENESIS

INFORMED CONSENT TO PROCEDURE

(PLEASE READ ALL QUESTIONS THOROUGHLY BEFORE SIGNING)

	INITIALS
• Are you pregnant or nursing? ☐ Yes ☐ No	____
• 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	____
• I have received, reviewed and understand the pre-procedural instructions as given to me and agree to follow them.	____
• 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.	____
• I understand that the color selection and color results in all procedures are not an exact science	____
• 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.	____
• 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.	____
• If I am a lens wearer, I realize that I must keep my lenses out the day of an eyeliner procedure	____
• 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.	____
• I realize this is an elective cosmetic procedure and is not medically necessary.	____
• It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling; fever blisters on the lip area following lip procedures and/or fading or loss of pigment.	____
• 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.	____
• I give my consent to **BEAUTY GENESIS** to confer with my physicians for medical informa-tion required for the safety of my procedures.	____
• 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.	____
• 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**.	____

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BEAUTY GENESIS

INFORMED CONSENT TO PROCEDURE

(PLEASE READ ALL QUESTIONS THOROUGHLY BEFORE SIGNING)

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.

Signature of Client: _____ Date Signed: ___/___/20___

Signature of Practitioner: _____ Date Signed: ___/___/20___

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