Derma-Mode, LLC

400 Indiana Street Suite 380, Golden, CO 80401 * 303-564-8528

Medical History Form

Today's Date: ________/______/________ Birth Date: _______/_____/__________

Name:____

Address, City, State:____

HomePhone:______________________________WorkPhone:___________________________

Email:____

Employer:________________________________Occupation:__________________________

Are you now or have you been under the care of a physician within the last two years?

____

If yes, please provide Physician's Name, address and Phone number:

____

Person to contact in an emergency:

Name:____

Number:____

List all medications you are currently taking, including Retin A, Glycolic Acid and Acutane:

____

List any drug, makeup, skin/food allergies (i.e., latex, soaps or cleansing creams)

____

Have you recently undergone a skin peel?

____

What products do you use for skincare?

____

Do you have or have you had any of the following conditions? (answer Yes or No):

______Abnormal Heart Condition

______ Cold Sores

______ Herpes Simples

______ Hemophilia

______ High or Low Blood Pressure

______ Prolonged Bleeding

______ Circulatory Problems

______ Epilepsy

______ Diabetes

______ Fainting Spells / Dizziness

______ Cataracts

______ Glaucoma

_______"Dry Eyes"

_______ Corneal Abrasions

_______ Eye Surgery or Injury

_______ Blepharoplasty (eyelid surgery)

_______ Visual Disturbances

_______ Cancer

_______ Tumors/ Growths/ Cysts

_______ Chemotherapy / Radiation

_______ Are you pregnant?

_______ Hepatitis

_______ Do you wear contact lenses?

_______ Do you use tobacco products?

______Are you using any eye drops or other ocular medication?

______ Have you ever experienced hyper-pigmentation from an injury?

______Are you currently taking aspirin or ibuprofen?

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Disclosure and Consent for Tattoo and Dermal Procedures

I, ____________________________________, as a client have requested that you describe the procedure to be utilized so that I may make an informed decision whether or not to undergo the procedure.

*You have described the recommended procedure to be used as micro Pigment Implantation, the process of implanting micro insertions of pigment into the dermal layer of skin. Micro pigment implantation is a form of tattooing used for the purpose of permanent cosmetic make-up and skin imperfection camouflage.

*I voluntarily request as my Intra-dermal cosmetic technician, Susan Maruyama and such association and technical assistance as she deem necessary to perform on my body the following procedure

*(circle one):
UPPER EYELIDS LOWER EYELIDS EYEBROWS FULL LIP COLOR LIPLINER
AREOLAS SCARCAMOUFLAGE OTHER:___________________________

*Please Initial:

_______ I hereby authorize Derma-Mode, LLC to take photographs of the work performed both before and after treatment, and I further authorize the use of said photographs to be used for the purpose of advertising.

_______ I hereby authorize Derma-Mode, LLC to take photographs of the work performed both before and after treatment to be maintained only in file.

_______ I have informed Derma-Mode, LLC that I am in good health and not under the care of any physician.

_______ I am currently under the care of a physician and I am being treated for the following condition(s):

Physician's Name:_______________________________________ Phone Number:________________
Address:____CityState_____________________
Zip:___________

Signature ____ **Date** ___________________

Disclosure and Consent for Tattoo and Dermal Procedures (continued) ...

Please Initial:
_______ I understand that this description of the procedure is not meant to scare or alarm me. It is simply an effort to make me better informed so that I may give or withhold my consent for this procedure.
_______ I have been told that there may be known and unknown risks and hazards related to the performance of the procedure planned for me and I understand that no warranty or guarantees have been made to me as to the results.
_______ I acknowledge the manufacturer of the pigment to be applied requires spot testing and specifically disclaims any responsibility for any adverse reaction to applied pigments. I understand spot testing may identify individuals who develop an immediate allergic reaction to pigment; however, spot testing does not identify individuals who may have a delayed allergic reaction to pigment. I agree to (circle one):
RECEIVE /WAIVE a spot test prior to application and I agree to release Susan Maruyama, Derma-Mode, LLC, and pigment manufacturer(s) from any and all liability related to allergic reaction or any other reaction to applied pigments.
_______ I have been told that allergic reactions to pigment are very rare, however, they can and do occur and when they occur they can be serious and especially difficult and very troublesome to treat.
_______ I have been told that this procedure will involve pain and discomfort.
_______ I understand the markings are permanent and that there is a possibility of hyper pigmentation resulting from a procedure, especially in individuals prone to hyper pigmentation from a scar or other injury.
_______ I have been told that a follow-up procedure may be required (a minimum fee of $75.00).
_______ I have been told that there is a chance that I may experience a corneal abrasion.
_______ Other risks involved with the procedure may include, but not limited to: infections, allergic and other reaction(s) to applied pigments, allergic and other reaction(s) to products applied during and after the procedure, fanning or spreading of pigment (pigment migration), fading of color and other unknown risks.
_______ I accept full responsibility for any and all, present and future, medical treatment(s) and expenses I may incur in the event I need to seek treatment(s) for any known or unknown reason associated with the procedure planned for me.
_______ I have been given an opportunity to ask questions about the procedures and the procedure to be used and the risks and hazards involved and I believe that I have sufficient information to give this informed consent.
_______ I have agreed that should I have a complaint of any kind whatsoever, I will immediately notify Derma-Mode, LLC and further agree any controversy or claim arising out of or relating to this consent and/or any signed contract between myself and Derma-Mode, LLC or the breach thereof, shall be settled by arbitration in the state of Colorado in accordance with the Rules of the American Arbitration Association and judgment of the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.
_______ I understand that if I have an infection, adverse reaction or allergic reaction to the procedure, I must notify Derma-Mode, LLC, a health care practitioner.
_______ I certify this form has been fully explained to me and I have read it or it has been read to me. I understand its contents.
_______ I have received a copy of the Post Procedure Instructions. It has been fully explained to me and I have read it or it had been read to me. I understand its contents.

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Date: ______________________________

Name: ______________________________

Address: ______________________________

City/State: ______________________________ Zip: ______________

Home Phone: ____________________ Work Phone: ____________________

Referred By: ______________________________

Fees Discussed: ______________________________

Procedure Request: ______________________________

____

Areas of Concern: ______________________________

____

(To be completed by Derma-Mode, LLC)

Pigment(s) Used: ______________________________

____

Lot # & Batch #: ______________________________

____

Expirations Date: ______________________________

____

Machine(s) Needle(s) Used: ______________________________

____

Anesthetic Used: ______________________________

____

Touch-Up(s) Done On: ______________________________

____

____

____

____

Additional Notes: ______________________________

____

____

____

____

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____

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After Care Instructions

Post Procedure Instructions FOR ALL PROCEDURES
(Eyebrows, Eyeliners, Lip Liner/Full Lips, Areola, and Camouflage)

Immediately Following Cosmetic Tattoo Procedure:
* Apply ice to treated area for 10-20 minutes. Ice helps reduce swelling and aids in healing.

Days 1-5: Before showering/cleansing, apply Aqua-Phor liberally to the treated area to act as a barrier.
* After showering/cleansing, remove initial application of Aqua-Poor and reapply a thin layer (as thin as chapstick) to treated area.

For 14 days following application of permanent cosmetics:
• Apply Aqua-Phor sparingly 2-3 times a day for 7-10 days following the procedure, using a clean cotton swab; not your fingertips.

• Do not rub or pick at the epithelial crust; allow it to flake off on its own. There should be absolutely no scrubbing, no cleansing creams or chemicals. Do not expose treated area to full pressure of the water in the shower.

• Do not soak treated area in bath, swimming pool or hot tub. Do not swim in fresh, salt or chlorinated pool water.

• Do not expose the treated area to the sun.

• Use a total sun block after the procedure area has healed to prevent future fading of pigment color.

• Do not use mascara or eyelash curler for seven days post procedure. When you resume use, purchase a new tube. The old tube has bacteria in it.

- Use sterile bandages and dressing when necessary. (Areola and Camouflage procedure cannot be guaranteed. This is an experimental procedure.)

- Touch-up procedures must be made between 30-60 days following the procedure. Additional fees will apply for touch-ups after 60 days following the procedure.

I understand that at the first sign of an infection, adverse, reaction or allergic reaction to the procedure, I must notify Derma-Mode, LLC, a health care practitioner.

Failure to follow post-treatment instructions may cause loss of pigment, discoloration or infection. Remember, colors appear brighter and more sharply defined immediately following the procedure. As the healing progresses, color will soften. A touch-up procedure may or may not be necessary. Final results cannot be determined until healing is complete.