BELLA VIA
Skin and Body Therapies

BROW LAMINATION INTAKE FORM

Name:_____ DOB:_____ Age:_____ Gender:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell:_____ Work: _____

Email Address:_____ Occupation:_____
(Your email address will be used for appointment confirmations, quarterly newsletters, and to alert you of specials and promotions.)

How were you originally referred to Bella Via? (Please circle and add note if applicable.)
Dr. Colville Dr. Zavell Website Friend: _____ Other: _____

AREA SPECIFICS

Is this the first time that you have had a brow lamination service? Yes No
If no, how long ago did you receive treatment? _____
Are you planning to attend a special event (wedding, reunion, other)? If so, when?_____
Please indicate if you have had any of the following treatments within the last 60 days:
□ Lash Tinting □ Lash Lift/Perm □ Eyelash Extensions □ Semi-Permanent Mascara
□ Brow Tinting □ Brow Henna □ Microblading □ Facial Tattooing

Do you currently have a sunburned or windburned face? Yes No
If yes, please list reason:_____
Do you tan via artificial tanning beds or booths? Yes No
If yes, when was your last visit?_____
Are you pregnant or lactating? Yes No
Have you had facial waxing within the last 3-5 days? Yes No
Have you shaved your face within the last 3-5 days? Yes No
Do you have regular dermal filler injections? Yes No
Do you have regular Botox injections? Yes No
Are you currently using anti-acne medications such as accutane, doxycycline, or epiduogel? Yes No
If yes, how long have you been using it?_____
Are you currently using anti-aging creams such as Retin-A, AHA's, or BHA's? Yes No
How frequently?_____Where do you apply it?_____
Please circle all allergies and/or sensitivities:
Aloe Vera Ammonia Apples Aspirin Citrus Grapes Hydroquinone
Latex Milk Perfumes Other:_____
Please list all drug allergies: _____

Please check any of the following that apply to you:

□ Eczema/Psoriasis □ Dermatitis □ Dry Skin □ Sores/Open Wounds □ Ringworm
□ Herpes Simplex □ Chicken Pox □ Shingles □ Conjunctivitis □ Impetigo
□ Blepharoplasty □ Rhytidectomy □ Microdermabrasion □ Chemical Peels □ Spray Tans
□ Severe Illness □ Flu Symptoms □ Thyroid Diseases □ Chemotherapy □ Iron Deficiency
□ Alopecia □ Trichotillomania □ Folliculitis □ Topical Steroids □ Brow Growth Serums
□ Oral Contraceptives □ Hormonal Replacement Therapy □ Hypersensitive Eyes or Skin
□ Exposure to Chemicals in Swimming Pools, Bleach, Hair Dye, or Perms
□ Disease/Disorder that causes Shaking, Twitching, or Erratic Movements

Brow Lamination Consent Form

_____ Do not perform *Brow Lamination* if any of the following contraindications exist: Alopecia, Trichotillomania, Bells Palsy, Sjogren's Syndrome, or any disease/disorder that causes shaking and/or twitching.

_____ I agree to get a doctors referral if I am a post Chemotherapy patient.

_____ I understand that there are risks associated with having this procedure. I further understand that the procedure could cause swelling, redness, bumps, peeling and itchiness on or near the eyebrow and that eye irritation, eye itching, discomfort, and in rare cases, eye blurriness or infection can occur. I agree that if I experience any of these conditions, I will contact my technician and consult a physician at my own expense.

_____ I understand that there are no guarantees as to the results of this treatment due to many variables such as age, condition of skin, climate, etc.

_____ I understand that though my technician uses proper technique, instruments, adhesive, cleansers, and removers, my eyes may become temporarily irritated or in rare cases, require a physician's care. I release my technician from all liability associated with the procedure, which is performed with utmost attention to safety and proper application using tools and products that the technician has been professionally trained to use.

_____ The treatment that I will receive has been explained to me by my esthetician.

_____ I understand that this procedure is semi-permanent.

_____ I understand and consent to having my eyes closed and covered for the duration of the procedure.

_____ I understand and consent to removing contact lenses prior to the procedure.

_____ I hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-treatment care instructions as I am directed.

_____ I consent to having "Before" and "After" photographs of all procedures for the purpose of documentation in my file. These photographs **may** _____ or **may not** _____ (please initial one) be used anonymously on our website or in our brochure for advertising purposes.

_____ I certify that the above statements are true and correct, and that I, _____, having been advised and fully informed by my esthetician, _____ of Bella Via, concerning the nature of the service proposed and hereby authorize and direct them to perform this service as may be deemed necessary or advisable. My signature below constitutes my acknowledgement that I have read, understand and fully agree to the foregoing. I understand the caution and contraindications for the service proposed; give consent to the proposed service that has been satisfactorily explained to me and have all the information that I desire. I hereby give my consent and authorization voluntarily and release Bella Via Skin and Body Therapies and its agents of any claims that I have or may have in the future in connection with the described application or service.

_____ _____

Signature of Client Date Signature of Parent/Guardian Date

_____

Signature of Technician Date