CONFIDENTIAL PATIENT QUESTIONNAIRE & CONSENT FORM

NAME:_____ ADDRESS:_____

CITY:_____ ST:_____ ZIP:_____ PHONE#:_____

GENDER: M/F

E-MAIL:_____ AGE:_____

HOW DID YOU HEAR ABOUT US? Google/Yahoo YouTube Facebook Instagram

Referral Other_____

HAVE YOU EVER HAD ANY HAIR REPLACEMENT PROCESS?: YES/NO

IF YES, WHEN & WHAT:_____

LIFESTYLE CHOICES CAN SIGNIFICANTLY IMPACT THE RESULTS OF OUR TREATMENTS. THE FOLLOWING INFORMATION WILL ENABLE US TO BEST CUSTOMIZE YOUR COURSE OF TREATMENTS.

ARE YOU CURRENTLY A SMOKER? (if so, amount per day):_____

ALCOHOL INTAKE (type & amount per week):_____

HEAD WASHING FREQUENCY:_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (name & purpose):_____

_____

ARE YOU CURRENTLY TAKING ANY SUPPLEMENTS (vitamins name & purpose):

_____

_____

_____

NOTES (For Office Use):

CERTAIN CONDITIONS MAY RESTRICT OR PRECLUDE THIS TREATMENT. PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING, AND IF SO, HOW LONG AND DATE WHEN TREATED:

CONDITION	FOR HOW LONG?	DATE TREATED?
□ EPILIEPSY		
□ PACEMAKER/PACEMAKER LEADS		
□ MULTIPLE SCLEROSIS		
□ HAIR CONDITION		
□ CURRENTLY PREGNANT		
□ CANCER		
□ SKIN DISORDERS/ALLERGIES		

□ HIV POSITIVE □ HEPATITIS □ BLOOD DISORDER □ PSORIASIS □ ALOPECIA

CONDITION	FOR HOW LONG?	DATE TREATED?
□ INFLAMMATION, INFECTION, DISEASE OF SKIN		
□ RECENT SCAR TISSUE		
□ LACK OF NORMAL SKIN SENSATION		
□ ANY KNOWLEDGE OF SKIN ALLERGIES?		
□ ANY KNOWN CIRCULATORY PROBLEMS?		
□ PREVIOUS COSMETIC PROCEDURES OR SURGERY?		
□ DO YOU WEAR CONTACTS?		

TRUTH IN ADVERTISING: I understand that this treatment is not a replacement for surgical or medical procedures and that there are no guarantees, implied or otherwise, as to the results or benefits that I may obtain from the treatment. I also understand that optimal results may not be obtained even if all procedures are completed and followed correctly.

INFORMED CONSENT: I hereby authorize the scalp micro-pigmentation procedure and hereby relieve this facility and its employees, affiliates or contractors and hold them harmless from all liability for injury that may occur to me. I understand that this consent is being given in advance and is given voluntarily. I further understand that if I have any medical condition outlined above that I should first consult with my physician prior to beginning any program of this nature. The treatment professionals involved with this procedure shall not be liable for any injury or damages to any patient resulting from acts of active or passive negligence on the part of the treatment professional, its successors, assigns and any of the officers or agents of this facility.

I understand that photos will be taken to monitor and document progress and that will never be used on any reproductions of results, unless my permission is given.

PATIENT SIGNATURE:_____ DATE:_____

PATIENT PRINTED NAME:_____