LASH EXTENSIONS FORM

CLIENT NAME _____ DATE _____
FIRST NAME LAST NAME

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

OCCUPATION _____ BIRTHDATE _____

PHONE NUMBERS _____
HOME TELEPHONE NUMBER WORK NUMBER CELL NUMBER

PREFERRED NUMBER TO CONTACT? ☐ HOME ☐ WORK ☐ CELL OK TO LEAVE MESSAGE? ☐ YES ☐ NO

EMERGENCY CONTACT _____ PHONE NUMBER _____

WHOM CAN WE THANK FOR REFERRING YOU? _____

EMAIL ADDRESS (FOR SPECIALS & PROMOTIONS ONLY) _____

DO YOU HAVE AN UPCOMING SPECIAL EVENT? IF SO, WHAT IS THE EVENT? _____

HAVE YOU EVER HAD LASH EXTENSIONS? ☐ YES ☐ NO WAS IT A GOOD EXPERIENCE? ☐ YES ☐ NO

DESCRIBE: _____

HAVE YOU EVER EXPERIENCED ITCHING AND/OR SWELLING OF THE LIDS *AFTER* GETTING LASH EXTENSIONS OR FILLS? ☐ YES ☐ NO

HAVE YOU HAD ANY OTHER ALLERGIC REACTIONS? ☐ YES ☐ NO PLEASE DESCRIBE: _____

ARE YOU RECEIVING TREATMENT FOR ANY EYE INJURY OR ILLNESS? _____

PLEASE LIST ANY EYE MEDICATION(S) OR DROPS YOU ARE CURRENTLY USING: _____

ARE YOU ABLE TO LIE STILL ON YOUR BACK WITH YOUR EYES CLOSED FOR APPROXIMATELY 1.5 HOURS? ☐ YES ☐ NO

PLEASE CHECK OFF ALL THAT APPLY TO YOU

- ☐ Lasik eye surgery
- ☐ Allergies/watery eyes
- ☐ Recent medical treatment to the eye, lids or ducts
- ☐ Dry eye
- ☐ Pink eye
- ☐ Sty
- ☐ Cataract surgery
- ☐ Blepharoplasty
- ☐ Blepharitis
- ☐ Eczema on lids
- ☐ Psoriasis on lids
- ☐ Irritated or broken skin
- ☐ Accutane
- ☐ Recent chemical peel
- ☐ Chemotheraphy
- ☐ Permanent makeup
- ☐ Allergies to adhesive tape
- ☐ Allergies to latex
- ☐ Allergies to acrylic nails
- ☐ Lash loss
- ☐ Compulsive lash pulling
- ☐ Allergies to the preservative in saline solutions

PRODUCTS USED (ALL THAT APPLY)

- ☐ Eye shadow
- ☐ Pencil/Kohl liner
- ☐ Liquid liner
- ☐ Cream/smudge liner
- ☐ Cake liner
- ☐ Mascara
- ☐ Waterproof mascara
- ☐ Lash curler
- ☐ Lash growth treatment

PLEASE LIST THE NAMES OF THE FOLLOWING PRODUCTS USED: Makeup Remover _____ Facial Cleanser _____

WHAT BEST DESCRIBES THE LOOK YOU WOULD LIKE FOR YOUR LASHES? _____

I am stating that the foregoing information is correct and true. I give my consent to have lash extensions applied.

SIGNATURE _____ DATE _____

PRINT NAME _____

IMPORTANT AFTERCARE INSTRUCTIONS FOR LASH EXTENSIONS SHEET
I have received and read the "Important Aftercare Instructions for Lash Extensions Sheet." I understand the contraindications, risks and benefits associated with this procedure. **INITIAL** _____

LASH EXTENSIONS SENSATIONS
Please note that a slight tingling or burning sensation may be felt during the lash extension process from the fumes of the adhesive. **INITIAL** _____

CANCELLATION & NO-SHOW POLICY
If you cancel your appointment within 24 hours of your scheduled time, you will be charged 50% of your scheduled service. If you are a "no-show" for your scheduled appointment, you will be charged 100% of your scheduled service. **INITIAL** _____

☐ CLIENT HAS COME TO WINK LASH STUDIO WITH LASHES FROM ANOTHER SALON