KIBA Beauty ACADEMY

Customer Information Form

	Name	Date	
	Address	Email	
	Birth Date	Contact Number	

Check if you have ever suffered from the following:

Eczema	Stye	Diabetes
Sunburn	Conjunctivitis	Blood/circulatory disorder
Skin Cancer	Recent scar tissue	Hemophilia
Herpes	Moles	Kelloid
Psoriasis	Allergies	HIV

***Contact lenses must be removed during the proced.*

***If you have inflamation, swelling, cuts, or abrasions in the treatment area, the procedure cannot be done.*

- Are you pregnant of breatfeeding? **Yes** **No**
- Are you taking medication that could affect then treatment (blood thinners, roacutane, etc.)? **Yes** **No**
- Have you had any procedures or surgeries? **Yes** **No**

(any medical history include Botox, filler, laser, etc)

If yes, please write down, when and what procedure or surgery was received.

Any additional information

I have completed this form to the best of my ability and knowledge and agree to inform the technician of any changes in the above information. I have been informed and understand the contradictions to the requested treatments and agree that I do not have any condition(s) that would make the requested treatmemt unsuitable.

Client Signature

Technician's Signature