CONSULTATION DIAGRAM

Name: _____ Date of Birth: _____

Please draw the desired shape of your requested application (Initial Each Request):

Color Requested (healed): _____

Please circle the desired procedure:

Eyebrows Upper Eyeliner Lower Eyeliner Lip Liner Lip Shading

Areola Scar Beauty Mark

Please sign prior to your application:

Customer Signature: _____ Date: _____

Technician Signature: _____ Date: _____