TATTOO CONSENT FORM

NAME			
D.O.B.	AGE	PHONE	
ADDRESS	CITY	STATE	ZIP

PHYSICIAN		PHONE	
ADDRESS	CITY	STATE	ZIP

(if none or unknown, please check one of the options below)

- ☐ MedExpress, 8849 SR52, Hudson, FL 34667 (727) 863-7150
- ☐ Gulf Coast Medical Center, 11528 US Hwy 19, Port Richey, FL 34668 (727) 868-2151

EMERGENCY CONTACT PERSON		PHONE	
ADDRESS	CITY	STATE	ZIP

MEDICAL HISTORY

Do you have any allergies or medications, or use topical solutions?_____If yes, list:_____
Do you have any history of bleeding disorders?_____If yes, list:_____
Do you have any medical condition(s) we should be aware of prior to performing this procedure?_____
If yes, list:_____

I have been provided with information describing the procedure to be performed and instructions on aftercare. I have been made aware that if I have any signs or syptoms of infection, such as swelling, pain, redness, warmth, fever, unusual discharge or odor to contact my health care provider. It is also my responsibility to take care of the tattoo site according to the instructions provided, both verbally and in writing.

CUSTOMER SIGNATURE	DATE

TATTOO INFORMATION

(To be completed by the artist)

DESIGN DESCRIPTION	
PLACEMENT (Body Site)	LEFT / RIGHT
SKIN CONDITON	COMMENTS

ARTIST NAME_____ ARTIST SIGNATURE_____