Eyelash Intake Form

Referred By:

Client Information

Name: ______________________________________ Birthday: ______/_______/_____

Cell: _______________________________________ Anniversary: ______/______/______

Email: ____

Client Lash Health

Do you wear contact lenses? ☐ Yes ☐ No

Do you get watery eyes from allergies or have sensitive eyes? ☐ Yes ☐ No

Have you had any eye issues in the last 4 weeks? ☐ Yes ☐ No

Do you perm or tint your eyelashes? ☐ Yes ☐ No

Are you able to lie flat for more than 3 hours? ☐ Yes ☐ No

Do you use any eye products (e.g. eye drops, lash serum, etc.)? ☐ Yes ☐ No

If so, please list:

____

____

____

What type of makeup remover and mascara do you currently use?

____

_____

Do you have any allergies or sensitivities? If yes, please list any and all:

____

____

____

Do you have any medical conditions or recent surgery? Please list any and all:

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____

What about your eyelashes would you like to enhance?

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_____

Cancellation, No-Show, and Tardy Policy

We look forward to serving you and want every guest to have the best experience possible. To book any appointment we do require a card on file to hold your appointment time. That being said, **we require a 24-hour notice for cancelations of any service provided at Hair Peace. No-Call, No-Shows will be charged 50% of the services booked as a fee to the card on file**. Guests who arrive late for services may need to reschedule their appointments so that they do not interfere with other appointments booked. We do ask that you call beforehand if there are any issues making your appointment so we can accommodate you appropriately. By signing below at the bottom of this page, you are acknowledging these policies and agree to follow them.

Printed Name: _______________ Signature: _______________ Date: ___/___/___

Eyelash Enhancement Release

By signing this form below, I _______________ understand that eyelash extensions, lifting, tinting or any other eyelash treatments and services may cause skin injury such as, but not limited to skin irritation, lifting, bruising, redness, allergic reactions, or swelling. I have read the information and listened to the information and agree to always provide service provider with all information that may affect my service such as, but not limited to past treatments, skin care products, health or medical conditions, etc. as accurate to my knowledge. I give my permission to service provider to perform the scheduled services that we have discussed and we hold Hair Peace or any of its employees or partners harmless of any liability that may result of treatments received. I agree to follow all post care instructions set by my service provider. I also understand that my service provider will take every precaution to minimize or eliminate any negative side effects as much as possible.

Printed Name: _______________ Signature: _______________ Date: ___/___/___