American Nightmare Tattoo

Date: _____

Name: _____

Phone: _____

Address: _____

_____

Are you over 18 years of age? Yes No

Tattoo Design:

Body Part:

PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS

Do you have a history of Jaundice or Hepatitis within the last 12 months?	Yes	No
Do you have HIV or AIDS?	Yes	No
Do you have High Blood Pressure?	Yes	No
Do you have any medical condition that may interfere with the procedure?	Yes	No
Do you have any Skin Condition(s)?	Yes	No
Are you Pregnant or Nursing?	Yes	No

If you answered Yes to any of the questions above, please explain.

_____

_____

_____

YOU MUST BE AWARE THAT TATTOOS ARE PERMANENT. TATTOOS CAN ONLY BE REMOVED WITH A SURGICAL PROCEDURE THAT CAN LEAVE PERMANENT SCARRING.

BY SIGNING THIS FORM, YOU ARE RELEASING AMERICAN NIGHTMARE TATTOO FROM ANY LIABILITIES CONCERNING THE APPLICATION AND/OR THE HEALING PROCESS OF YOUR TATTOO.

Client Signature: _____

Artist Name: _____ Price: _____