DATE	SERVICE - TREATMENT	$Fee	Retail	Remarks / Therapist

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PROFESSIONAL SERIES

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IMPROVED!
2007

Name _____ *Skin Care Service Treatment* ™

Phone Res:_____Cell:_____Bus:_____eMail_____@____

Address_____State_____Zip_____Birthdate_____

Preferred Appt Times _____AM/PM Day _____ Appt. Freq. ☐ 1Wk ☐ 2 Wks ☐ 3 Wks ☐ 4 Wks Therapist _____Lic.#_____

DATE	SERVICE - TREATMENT	$Fee	Retail	Remarks / Therapist

✔☐Medical Alert: ☐ Bleeding ☐ Allergies ☐ Medications ☐ Service Complications ☐ _____

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