

Client Information Card

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Name _____

Nail Anniversary Date ___ / ___ / ___

Address _____

CSZip _____

Diabetic: Y ___ N ___

E-Mail _____

Allergies: _____

Home Phone (____) _____

Work Phone (____) _____

Cell Phone (____) _____

Special requests or needs:

Fax # (____) _____

Birthdate ___ / ___ / ___

referred by _____

Notes: Personal Information

Clients referred:

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Name _____ Date ___ / ___ / ___

Pictures: Before & After

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