CUSTOMER PROFILE

CUSTOMER NAME: (last, first, middle initial)			
MAILING ADDRESS:			
CITY:	**STATE/PROV:**	**ZIP/POSTAL CODE:**	**COUNTRY:**

DAYTIME TELEPHONE NO:	**EVENING TELEPHONE NO:** (if different)	**CELL PHONE NO:** (if applicable)

FAX NO: (if applicable)	**EMAIL ADDRESS:**

OCCUPATION	**BIRTHDAY:**

AGE:	**SKIN TYPE:**		**PRODUCT(S) PURCHASED:**
o 20-29	o Dry, Dehydrated	o Oily	o Skin Care
o 30-45	o Normal	o Troubled	o Color Cosmetics
o 46+	o Combination		o Specialty Treatment

CONDITIONS CUSTOMER WOULD LIKE TO ADDRESS: (may check more than one)

o Dryness o Oiliness o Blemishes o Fine Lines
o Spots & Discoloration o Dark Under Eye Circles o Uneven Skin Tone

	PRODUCTS	**TYPE/SHADE**	**SAMPLE DATE**	**FIRST PURCHASE DATE**	**REORDER DATES**							**COMMENTS**
SKIN CARE	Makeup Remover											
	Cleanser											
	Toner											
	Moisturizer											
	Renewal											
	Night Treatment											
	Blemish Treatment											
COLOR	Concealer											
	Foundation											
	Finishing/Powder											
	Eye Pencil/Liner											
	Eye Shadow											
	Mascara											
	Cheeks											
	Lip Pencil											
	Lip Gloss											
	Lipstick											