



# Center for Dermatology AND LASER SURGERY

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## Cosmetic Service Questionnaire

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**I am interested in the finding out about the following products and procedures:**

- BOTOX Cosmetic (Botulinum Toxin Type A)
  - Corrective Fillers
  - Skin Tightening
  - Skin and Hand Rejuvenation
  - Laser Skin Resurfacing
  - Pigmentation (Brown Spots)
  - Rosacea (Redness)
  - Body Contouring
  - Spider Vein Removal
  - Excessive Sweating
  - Micro-Dermabrasion
  - Hair Removal
  - Acne
  - LED Light Therapy
  - Chemical Peels
  - Skin Care Consultation
  - Other (please specify) \_\_\_\_\_
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Your Complimentary Treatment Consultation

\* How would you like us to contact you?

\* Method of contact you prefer. **PHONE** or **EMAIL ADDRESS**. Please fill out below:

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