

Patient Name: _____ Date: _____

Please indicate if you are interested in the following: (Please check all that apply).

- BOTOX® Cosmetic
- Restylane®, Juvaderm®, Perlane®, Collagen
- Fotofacial®/IPL Treatments (Face, Neck, Chest)
- Fraxel® Laser Resurfacing
- Liposuction
- Hair Laser Removal
- Removing Leg Veins and/or Spider Veins
- Removing Facial Veins
- Chemical/Glycolic Peels
- Skin Rejuvenation
- Skin Cancer Removal
- Sunscreen & Skin Care Products
- Other:* _____

This questionnaire will be used to assist our staff in determining the proper treatment for you.

Thank you for your time.