Kayal Dermatology & SKIN CANCER SPECIALISTS

COSMETIC SERVICES QUESTIONNAIRE

What additional cosmetic services would you like to learn about? Please check all that apply

Neurmodulators (Relax Muscles)
- ❑ Xeomen

Cosmetic Fillers (Lost Volume)
- ❑ Belotero
- ❑ Restylane Sylk
- ❑ Restylane Lyft
- ❑ Bellafill
- ❑ Radiesse
- ❑ Evolysse Form

Products for Skin Conditions
- ❑ Cleanse / Exfoliate
- ❑ Tone / Protect / Mask
- ❑ Anti-Aging
- ❑ Anti-Redness
- ❑ Lash Length/Fullness
- ❑ Skin Care Consultation

Laser Treatments
- ❑ Facial Veins (Telangectasia)
- ❑ Spider Veins - Legs
- ❑ Brown Spots / Melasma
- ❑ Rosacea (Facial Redness)
- ❑ Acne Scarring / Scar Revision
- ❑ Wrinkles / Lax Skin – Face
- ❑ Oil Control/ Reduce Pores
- ❑ Hyperhidrosis (Miradry)
- ❑ Skin Resurfacing (PSR)
- ❑ Skin Tightening / Body Contouring (Viora)

Esthetic Procedures
- ❑ Kybella
- ❑ Microdermabrasion
- ❑ Microneedling
- ❑ Microneedling + PRP
- ❑ Microneedling RF + PRP
- ❑ PRP for Hair Loss
- ❑ Chemical Peels
- ❑ Extractions
- ❑ IPL
- ❑ Dermaplaning
- ❑ Facial/ Acne Scar Correction

Advanced Surgical Procedures ❑
- Sclerotherapy – Leg Veins
- ❑ Blepharoplasty (Eye Lids)
- ❑ Laser Liposuction
- ❑ Laser Lipo Fat Transfer
- ❑ Tattoo Removal
- ❑ Medium Depth Chemical Peel
- ❑ Mole / Birthmark Removal
- ❑ Keratosis/Oil Gland Removal
- ❑ Skin Tag Removal
- ❑ Keloid Removal
- ❑ Cyst/Lipoma Removal

Coolsculpting ❑

Other please specify:

_____
_____
_____
_____
_____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

EMAIL LIST

Would you like to join our exclusive mailing list?

Emails **promotions** and **special offers** on products, services and cosmetics procedures are sent periodically. *(Special offers only valid through email)*

❑ I'm not interested in any cosmetic services at this time	***Email address:***

PATIENT PHOTO CONSENT AND RELEASE FORM

Patient Name: _____ Date of Birth: _____

I consent for photographs and/or images to be taken of me by Kayal Dermatology and Skin Cancer Specialist or a representative. I understand the images will be part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website,print,digital or social media).

By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me.

I further acknowledge that my participation is voluntary and agree that use of any photographs and/or images confers no rights of ownership or royalties whatsoever. I hereby release Kayal Dermatology and Skin Cancer Specialists and/or a representative involved in the creation of or publication of educational or marketing materials, from liability for any claims by m or any third party in connection with my participation.

- For educational purposes (medical teaching or training) YES or NO
- For marketing and advertising purposes(website,print,digital, or social media) YES OR NO

By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via written request submitted to Kayal Dermatology and Skin Cancer Specialists ATTN: Privacy Officer at 141 Lacy Street, STE. 200 Marietta, GA 30060

Patient Signature: _____ Date: _____