



Patient Intake Form

Demographics

First Name: _____

Middle Name: _____

Last Name(s): _____

Date of Birth (MM/DD/YYYY): _____

Preferred Language: _____

Home Address: _____

Phone Number: _____

Email Address: _____

Sex Assigned at Birth: Male Female Other

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

How did you hear about us? _____

Reason for Visit & Aesthetic Goals

Please list any questions or concerns that you have with your skin/body and/or the reason for your visit:

Previous aesthetic treatments (type/date/provider):

Any prior complications? No Yes (explain):

Medical History

Have you been under the care of a physician, dermatologist, or other clinician within the past year? No Yes (specify provider and reason):

Do you have/have you had any of the following conditions (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Hormone Imbalance | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Heart disease/problem | <input type="checkbox"/> Cancer (type/date): _____ |
| <input type="checkbox"/> Spinal injury | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Autoimmune disorder (lupus, RA, etc.) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Bleeding/clotting disorder | <input type="checkbox"/> Skin disorders (eczema, psoriasis, etc.) |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Keloid or hypertrophic scarring history |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herpes simplex (cold sores) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Neurological disorder (e.g., myasthenia gravis) | |



Patient Intake Form

Surgeries (including cosmetic and plastic surgery):

Have you ever experienced claustrophobia? No Yes

Medications & Allergies

Current Medication List (please list all current prescriptions, over-the-counter (OTC) drugs, and supplements)

Medication Name (specify dose form: Tablet, Capsule, Powder, etc.)	Dosage	Route	Frequency	Prescriber, if any

Route options include: oral, which is when a person swallows a drug / intraocular, or into the eye / intraotic, or into the ear/ nasal, or through the nose / sublingual, or under the tongue / buccal, between the gums and the mouth cheek / inhalation or nebulization, or inhaled through the respiratory system / enteral, which is when a person receives the drug directly into their digestive tract / rectal, or through the rectum / vaginal, or through the vagina / transdermal, or through the skin / subcutaneous, or under the skin / intramuscular, or via an injection into a muscle / intravenous, or into a vein / intra-arterial, or into an artery / intraosseous, or into the bone marrow

Are you taking any blood thinners / NSAIDs / anticoagulants? No Yes

Have you ever experienced an allergic reaction to any of the following? (check all that apply):

- Lidocaine/topical anesthetics
- Latex
- Antibiotics
- Botulinum toxin
- Hyaluronic acid fillers
- Cosmetics
- Sunscreens
- Iodine
- AHAs
- Fragrance
- Shellfish
- Food (specify): _____
- Other: _____

Reaction details:

Social & Lifestyle Factors

- Do you smoke or vape? No Yes
- Alcohol use? No Yes
- Do you follow a restricted diet? No Yes
- Exercise regularly? No Yes
- What is your stress level? High Medium Low
- Do you wear contact lenses? No Yes



Patient Intake Form

Have you been exposed to the sun or a tanning bed within the last 48 hours? No Yes

Skin & Aesthetic Profile

Skin type: Dry Oily Combination Normal

Fitzpatrick Type: I (Total score is 0-7) II (Total score is 8-16) III (Total score is 17-25) IV (Total score is 25-30) V-VI (Total score is >30)

(please use the following questionnaire to answer your Fitzpatrick Type)

Score	0	1	2	3	4
What is the colour of your eyes?	Light blue, Grey, Green <input type="checkbox"/>	Blue, Grey or Green <input type="checkbox"/>	Blue <input type="checkbox"/>	Dark Brown <input type="checkbox"/>	Brownish Black <input type="checkbox"/>
What is the natural colour of your hair?	Sandy Red <input type="checkbox"/>	Blonde <input type="checkbox"/>	Chestnut/ Dark Blonde <input type="checkbox"/>	Dark Brown <input type="checkbox"/>	Black <input type="checkbox"/>
What is the colour of your skin (non exposed areas)?	Reddish <input type="checkbox"/>	Very Pale <input type="checkbox"/>	Pale with Beige tint <input type="checkbox"/>	Light Brown <input type="checkbox"/>	Dark Brown <input type="checkbox"/>
Do you have freckles on unexposed areas?	Many <input type="checkbox"/>	Several <input type="checkbox"/>	Few <input type="checkbox"/>	Incidental <input type="checkbox"/>	Dark Brown <input type="checkbox"/>
What happens when you stay in the sun too long?	Painful redness, blistering, peeling <input type="checkbox"/>	Blistering followed by peeling <input type="checkbox"/>	Burns sometimes followed by peeling <input type="checkbox"/>	Rare burns <input type="checkbox"/>	Never had burns <input type="checkbox"/>
To what degree do you turn brown?	Hardly or not at all <input type="checkbox"/>	Light colour tan <input type="checkbox"/>	Reasonable tan <input type="checkbox"/>	Tan very easy <input type="checkbox"/>	Turn dark brown quickly <input type="checkbox"/>
Do you turn brown within several hours after sun exposure?	Never <input type="checkbox"/>	Seldom <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Often <input type="checkbox"/>	Always <input type="checkbox"/>
How does your face react to the sun?	Very sensitive <input type="checkbox"/>	Sensitive <input type="checkbox"/>	Normal <input type="checkbox"/>	Very resistant <input type="checkbox"/>	Never had a problem <input type="checkbox"/>
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago <input type="checkbox"/>	2-3 months ago <input type="checkbox"/>	1-2 months ago <input type="checkbox"/>	Less than a month ago <input type="checkbox"/>	Less than 2 weeks ago <input type="checkbox"/>
Did you expose the area to be treated to the sun?	Never <input type="checkbox"/>	Hardly ever <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Often <input type="checkbox"/>	Always <input type="checkbox"/>

Which skincare and cosmetic products are you currently using? (retinoids, acids, etc.):

FEMALE PATIENTS ONLY

Are you taking any oral contraceptives/using hormonal therapy? No Yes

Are you pregnant or trying to become pregnant? No Yes

Are you breastfeeding? No Yes

What is the date of your last menstrual cycle? _____

On hormonal therapy/birth control? No Yes

Are you experiencing any menopause problems? No Yes



Patient Intake Form

Contraindication Screening

Do you use or have you ever used Adapalene Hydroxyl Acid, Glycolic Acid, AHA, Accutane, Retin-A, Renova, Deferin, Salicylic Acid or any vitamin A derivative product (Accutane No Yes (if yes, explain which product and how long ago)

Do you currently have:

- Active infection
- Open wounds
- Rash in treatment area

Photo & Media Consent

I consent to photos being used for office use. No Yes

I consent to photos being used for advertising. No Yes

I would like to receive promotions and communications via email. No Yes

General Informed Consent / Patient Attestation & Liability Waiver

I understand that I have read, completed, and provided the information in this intake documentation truthfully and to the best of my knowledge, and that this constitutes full and complete disclosure of my medical history. I acknowledge that this written disclosure supersedes any prior verbal or written communications. I understand that withholding information or providing inaccurate or incomplete information may result in contraindications, adverse reactions, or complications from treatments received. I accept full responsibility for updating the provider and clinical staff regarding any changes in my medical history, medications, or health status.

I acknowledge that all procedures performed are medical treatments conducted under appropriate medical direction and supervision in accordance with applicable laws and regulations in the State of Florida. I understand that aesthetic treatments are elective in nature, and I voluntarily consent to undergo such treatments.

I understand that while treatments are recommended to achieve optimal aesthetic outcomes, results vary from patient to patient, and no guarantees or warranties, express or implied, have been made regarding the results I may achieve. I recognize that aesthetic medicine is not an exact science and that outcomes may differ based on individual factors.

I further understand that all medical and aesthetic procedures carry inherent risks. These risks may include, but are not limited to, temporary or permanent bruising, swelling, redness, pain, tenderness, infection, allergic reactions, hyperpigmentation or hypopigmentation, scarring, delayed healing, and asymmetry or unsatisfactory aesthetic outcomes. I also understand that more serious, although rare, complications may occur, particularly with injectable and energy-based treatments, including but not limited to vascular occlusion, tissue necrosis, nerve injury, and vision impairment, including blindness.

I confirm that I have had the opportunity to ask questions regarding the nature, purpose, risks, benefits, and alternatives to the proposed treatments, and that all of my questions have been answered to my satisfaction. I understand that I have the right to decline any treatment at any time.

By signing below, I voluntarily consent to treatment and acknowledge that I assume responsibility for any risks, known or unknown, associated with the procedures. To the fullest extent permitted by law, I agree to release and hold harmless OD Vitality, LLC, its medical providers, practitioners, employees, and affiliates from liability for any complications or outcomes associated with the treatments performed, except in cases of gross negligence or willful misconduct.

Patient Signature

Date of Signature

Pre & Post Care Acknowledgment

I acknowledge that I have received detailed verbal and/or written pre-treatment and post-treatment instructions related to the procedures I will undergo. I understand that these instructions are a critical component of my treatment and recovery, and that failure to strictly follow them may increase the risk of complications, including but not limited to infection, poor healing, scarring, pigmentation changes, suboptimal results, or other adverse outcomes.

I agree that it is my sole responsibility to adhere fully to all pre- and post-care instructions provided by OD Vitality, LLC and its medical providers. I understand that individual results and healing outcomes are directly affected by my compliance with these instructions.



Patient Intake Form

I further acknowledge and agree that failure to follow pre- and post-treatment instructions, whether in whole or in part, may negatively impact my results and may increase the likelihood of complications. In such cases, I accept full responsibility for any resulting outcomes.

To the fullest extent permitted by Florida law, I agree to release, indemnify, and hold harmless OD Vitality, LLC, its physicians, medical director, providers, contractors, and staff from any and all liability, claims, damages, or expenses arising from or related to my failure to adhere to the provided pre- and post-treatment instructions. This includes, but is not limited to, complications, unsatisfactory results, or the need for corrective treatments.

I acknowledge that I have had the opportunity to ask questions regarding these instructions and fully understand their importance. I voluntarily accept these terms as a condition of receiving treatment.

Patient Signature

Date of Signature

Acknowledgment of Receipt of Privacy Notices

I acknowledge that I have had the opportunity to review the Notice of Privacy Practices for OD Vitality, available at <https://odvitality.com/> which sets forth OD Vitality’s privacy practices and my rights regarding privacy of my protected health information.

I understand that I may request a physical copy of the Notice of Privacy Practices, that policies may change, and that I may request restrictions on how my information is used.

Patient Signature

Date of Signature

FOR OFFICE USE ONLY

We have made every possible effort to obtain written acknowledgement of receipt of our notice of privacy practices from this patient but it could not be obtained because:

- The patient refused to sign
- Due to an emergency situation, it was not possible to obtain an acknowledgement
- We were unable to communicate with the patient
- Other (please provide specific details)

Employee Signature

Date of Signature

Financial Policy

I understand and agree to the following financial policies of OD Vitality, LLC:

- All services rendered are elective medical aesthetic treatments and payment in full is due at the time services are provided unless otherwise agreed upon in writing. I understand that pricing may vary based on the amount of product used, time required, or individualized treatment plans determined by the provider.
- I acknowledge that aesthetic outcomes cannot be guaranteed, and that I am paying for the provider’s time, expertise, and products used—not for a specific result. Therefore, all services rendered are non-refundable under any circumstances, including dissatisfaction with aesthetic outcomes.
- I understand that prepaid packages, memberships, or promotional services are subject to expiration dates and specific terms, which will be disclosed at the time of purchase. Unused services beyond the expiration date may be forfeited unless otherwise required by law.
- I agree to provide at least 24 notice for appointment cancellations or rescheduling. Failure to do so, or failure to appear for a scheduled appointment, may result in a cancellation or no-show fee (25% of service fee), which I authorize the practice to charge to my card on file.



Patient Intake Form

- I understand that late arrivals may result in modification or forfeiture of my appointment at the provider's discretion, and may be treated as a missed appointment.
- I acknowledge that additional treatments, touch-ups, or corrections may require additional charges, unless explicitly included in a written treatment plan.
- In the event of any outstanding balance, I agree that OD Vitality, LLC reserves the right to charge my card on file and/or pursue collection efforts as permitted by law. I agree to be responsible for any reasonable costs of collection, including administrative fees, collection agency fees, and attorney's fees if applicable.

By signing below, I acknowledge that I have read, understand, and agree to these financial policies, and I authorize OD Vitality, LLC to charge my payment method on file in accordance with these terms.

Patient Signature

Date of Signature

Card-on-File Authorization & Payment Consent

I authorize OD Vitality, LLC to securely maintain my credit/debit card information on file for the purpose of facilitating payment for services rendered, products purchased, and any applicable fees in accordance with the Financial Policy Agreement.

I understand and agree that my card on file may be charged for the following, without additional prior notice:

- Services performed on the day of treatment
- Packages, memberships, or retail purchases authorized by me
- Applicable cancellation or no-show fees in accordance with clinic policy
- Late cancellation fees (less than the required notice period)
- Outstanding balances not paid at the time of service
- Fees associated with missed appointments or same-day cancellations
- Approved add-on services performed during my visit

I acknowledge that I am responsible for maintaining a valid and up-to-date payment method on file and agree to promptly update my information if my card changes or expires.

I further authorize OD Vitality, LLC to charge my card on file for any outstanding balances, including those resulting from declined transactions at the time of service. In the event a charge is declined, I agree to provide an alternative form of payment immediately.

I agree not to dispute or initiate a chargeback with my financial institution for services that have been rendered, fees incurred in accordance with signed policies, or products received. In the event of a chargeback or payment dispute, I acknowledge that OD Vitality, LLC reserves the right to provide documentation of my signed agreements and treatment records as evidence of authorization. I further agree to be responsible for any fees, costs, or expenses incurred by OD Vitality, LLC as a result of such disputes, including administrative fees and, where permitted by law, collection and legal costs.

I understand that all charges will comply with applicable laws and card network regulations, and that I will receive a receipt upon request.

By signing below, I confirm that I have read, understand, and voluntarily authorize the use of my card on file under these terms.

Cardholder Name as Shown on Card: _____

Card Number: _____

Expiration Date: _____

Billing ZIP Code: _____

Cardholder Signature

Date of Signature