Nova
MEDICAL SPA & LASER CENTER

New Patient Form

Name _____ Date of Birth _____ Age _____ Gender: M F
Last Name First Name M.I.

Address_____
Street Apt# City State Zip

Mailing Address (if different from above) _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email _____

Social Security # _____ Status: S M D W

Occupation _____ Employer _____ Work Phone ( )_____

Emergency Contact _____ Relation _____ Phone ( ) _____

Primary Care Physician _____ Phone ( ) _____

Responsible Party (if patient is a minor) _____ Relation _____ DOB _____ SS#_____

How did you hear about Nova Medical Spa & Laser Center?

Internet (website, yelp, facebook, etc) _____ Friend/Family _____ Hair Salon/Stylist _____ Other _____

Referred By _____
Name Relation

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance and that payment is due at the time of service unless a repayment plan has been determined with Nova Medical Spa and Laser Center at the time of service. I understand that a copy of the HIPPA laws will be provided to me upon request. I am open to review these rules and discuss any areas in which I have questions. I have the following rights in regards to my medical record: I can consent to or authorize the use and disclosure of the record with an authorization for release of information form. I may request restrictions on certain uses and disclosures of my record. I may receive confidential communication and receive a copy of my record. I may request an amendment of my record. I may complain about alleged violations to the office and DHHS. I allow Nova Medical Spa and Laser Center to send communications to me via regular mail without being marked "personal or confidential" and to leave voicemail messages at my home or on my cellular phone.

All correspondence including faxes, emails, electronic transfers, telephone calls etc. will be considered HIPPA compliant with your signature of this consent.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

Please sign below to accept these terms:

_____ _____ _____
Patient Signature Print Name Date

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