**La Nouvelle Medical Spa**

1700 N Rose Ave #230

Oxnard, Ca 93030

(805)988-2638

**Medical Director: Antoine Hanna, M.D.**

**Please print clearly and complete all information**

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

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**

**Social Security:**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_**

**Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_ Cell:(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-mail Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_.com**

**Circle one: Married Partnered Single**

**Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_**

**Please circle how you heard about our business.**

**Referred By (Circle): Radio (Laser or La Mejor) Internet Yelp Friend:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Notice to consumers: Medical doctors are licensed and regulated by the Medical Board of California. (800) 633-2322.**

**I hereby acknowledge that all facts related to Dr. Hanna are true. I am aware that I have access to my medical records per HIPPA laws. I am aware that my records are confidential. I am aware that I have the right to my privacy. I am aware that my records cannot be shared with 3rd parties without my permission, including my friends and family members.**

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have ADVANCE DIRECTIVE? \_\_\_\_\_\_YES \_\_\_\_\_NO**