SHERIF KHATTAB, M.D., INC
AESTHETIC, PLASTIC & RECONSTRUCTIVE SURGERY

23365 HAWTHORNE BLVD., SUTE 102
TORRANCE, CA 90505

TEL: (310) 325- 2100
FAX: (310) 325 -7400

PATIENT REGISTRATION FORM

(PLEASE PRINT CLEARLY)

PATIENT'S NAME:_____SS#_____

ADDRESS:_____DRIVER'S LIC.#_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____WORK PHONE:_____CELL:_____

DATE OF BIRTH:_____AGE:_____E-mail :_____

OCCUPATION:_____EMPLOYER:_____

CITY:_____STATE:_____ ZIP:_____TEL:_____

IN CASE OF EMERGENCY CONTACT:_____

RELATIONSHIP TO PATIENT: _____TEL: _____

RESPONSIBLE PARTY INFORMATION IF PATIENT IS NOT THE INSURED

NAME:_____ D.O.B:_____

SS #:_____ DRIVER'S LIC:_____

ADDRESS:_____ CITY:_____

STATE:_____ ZIP: _____ PHONE:_____

EMPLOYER: _____ ADDRESS: _____

STATE:_____ZIP:_____ PHONE:_____

PRIMARY INSURANCE:

NAME:_____

POLICY HOLDER:_____

SECONDARY INSURANCE:

NAME:_____

POLICY HOLDER:_____

REFFERED BY:

NAME:_____

FAMILY PHYSICIAN:

NAME:_____

SHERIF KHATTAB, M.D., INC
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TO ALL MY PATIENTS

Charges are determined to be usual, customary and reasonable fees for the professional services provided. If you have any health or accident insurance, Medicare, or any type of payment agreement with any insurance company or government agency, please be reminded that this does not necessarily mean that you will be reimbursed the full amount of my fees. In such instances, please understand that you will remain responsible for any unpaid balances as well as all legal fees and other costs of collection and interests at the highest rate allowed by law.

I authorize payment to be made directly to Sherif Khattab, M.D., Inc for medical or surgical benefits otherwise payable to me under the terms of my insurance. Request for payment of benefits from any health or accident insurance, Medicare, authorizes me to release any information acquired in the course of your examination or treatment (surgery).

If you have any questions regarding my fees or professional services I will be happy to discuss them with you.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

Signature:_____Date:_____

Medical photographs are utilized in plastic surgery, as are X-rays and electrocardiograms in medicine. Such records are kept and provided as reference points for past and future treatments and for patient education.

I AGREE TO RELEASE PHOTOGRAPHS (pre-operative, intra-operative and post-operative) as needed by Sherif Khattab, M.D.

Signature:_____Date:_____

Our **privacy notice** describes how your medical information may be used and provided to others for treatment, payment and other purposes required or allowed by law.

I HAVE READ a copy of Beyond Beautiful, Sherif Khattab, M.D., Inc.'s Notice of Privacy Practices.
(Please ask for it if you have not received it)

Signature:_____Date:_____

NOTICE TO CONSUMERS

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

Sherif Khattab, M.D.,Inc
310-325-2100

Social

Age_____Sex: _____ Occcupation:_____

Responsible adult available to assist during recovery period Y N
Relationship_____

Habits

Smoke Y N Amount_____ Coffee/Tea/Cola Y N Amount_____
Alcohol Y N Amount_____ Daily exercise Y N Amount_____

Medications: List dose/ number of pills per day

Presciption drugs: Non-presciption (include vitamins & herbs):

_____ _____
_____ _____
_____ _____
_____ _____

Regular Aspirin use Y N dosage and frequency_____
NSA (Advil, Motrin, Ibuprofen): Y N dosage and frequency_____
Cortisone Injections Past year Y N dosage and frequency_____
Drug Allergy Y N List drugs and type of reaction_____
_____

Latex Allergy: Y N Tape Allergy Y N

Family History

Have any blood relatives ever had the following problems:

Abnormal Bleeding	Y N	Coronary Surgery	Y N
Kidney Disease	Y N	Abnormal clotting	Y N
Diabetes	Y N	Tuberculosis	Y N
Anesthetic Problems	Y N	Heart Attacks	Y N
Cancer	Y N	Hypertension	Y N
Other Serious Illness	Y N		

Please describe questions with a YES answer:_____
_____
_____

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Personal Past History

Have you ever had?

Abnormal bleeding	Y N	Asthma	Y N	Hypertension	Y N
Abnormal clotting	Y N	Diabetes	Y N	Sleep Apnea	Y N
Acid Regurgitation	Y N	Snoring	Y N	Fainting Spells	Y N
Heart attack	Y N	Anemia	Y N	Weight change	Y N
Hepatitis	Y N	Angina	Y N	Other serious illness	Y N

Please describe questions with a YES answer:

_____
_____
_____
_____

Have you ever received a transfusion? Y N If yes, what year?_____

Have you been tested for HIV? Y N
If yes, what year?_____ Test results: negative positive

Do you wear:
Contact lenses Y N Eye glasses Y N Hearing Aid Y N Dentures Y N

List previous surgeries including the year and type of procedure:

_____
_____
_____
_____

Indicate the type (s) of anesthesia received in the past and list any complications/reactions you experienced:

____ Local anesthesia-complication /reactions:_____
____ General anesthesia-complications/reactions:_____
____ Spinal/Epidural-complications/reactions:_____

Date last seen by Primary Care Physician:_____
Primary Care Physician name:_____ Phone_____

Women patients only:
Number of pregnancies_____ Number of children_____ Did you breast feed? Y N
Last menstrual period_____