

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

2802 PACIFIC COAST HWY.
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: _____
EMPLOYER: _____ OCCUPATION: _____
ADDRESS: _____ CITY: _____
STATE: _____ ZIP: _____ TEL _____ SPOUSE'S NAME: _____
OCCUPATION: _____ TEL : _____
IN CASE OF EMERGENCY CONTACT: _____

RESPONSIBLE PARTY INFORMATION IF OTHER THAN YOURSELF

NAME: _____ SS# _____
RELATIONSHIP TO PATIENT: _____ DRIVER'S LIC: _____
DATE OF BIRTH: _____ EMPLOYER: _____
ADDRESS: _____ CITY: _____
STATE: _____ ZIP: _____ PHONE: _____

PRIMARY INSURANCE:

NAME: _____
POLICY HOLDER: _____
ID# _____
INJURY RELATED YES ___ NO ___

SECONDARY INSURANCE:

NAME: _____
POLICY HOLDER: _____
ID# _____
DATE OF NJURY _____

REFERRED 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 my fees resulting from the need to use collection agencies, legal advice for collection of unpaid balances.

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 question regarding my fees or my professional services I will be happy to discuss them with you.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

Signature: _____ Date: _____

I agree to release photographs (pre-operative, intra-operative and post-operative) as needed by Sherif Khattab, M.D.

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.

Signature: _____ Date: _____

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310-325-2100

Name: _____ Date _____

Social

Age ___ Sex: M F Married: Y N occupation _____
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 or number of pills per day

Prescription drugs: _____ Non prescription (include Vitamins and 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

Previous Surgery, year and type of procedure: _____

Indicate the type (s) of anesthesia received in the past, 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 _____ Last menstrual period _____
Did you breast feed? Y N