

**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**  
**AESTHETIC, PLASTIC & RECONSTRUCTIVE SURGERY**

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

**Sherif Khattab, M.D., Inc**  
**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