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

23365 HAWTHORNE BLVD., SUITE 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:____________________CELL:_____________________WORK:_________________

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:_________________________

PHONE:____________________________________ E- mail: __________________________________

PRIMARY INSURANCE:

NAME:____________________________________

POLICY HOLDER:__________________________

SECONDARY INSURANCE:

NAME:__________________________________

POLICY HOLDER:_______________________

PHARMACY NAME: ____

PHONE: ____________________________________ FAX: __________________________________

ADDRESS: ____

REFFERED 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 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.

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

Patient Name:_______________________________Date_________________________

Social

Age_______Sex: M F Married: Y N Occupation________________________
Responsible Adult available to assist during recovery 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	Tubercolosis	Y	N
Anesthetic Problems	Y	N	Heart Attack	Y	N
Cancer	Y	N	Hypertension	Y	N
Other Serious Illness	Y	N			

Please describe questions with a Yes answer:____
____
____
____

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310-325-2100

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_____Last menstrual period__________

Did you breast feed? Y N