

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: _____ 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:

SECONDARY INSURANCE:

NAME: _____

NAME: _____

POLICY HOLDER: _____

POLICY HOLDER: _____

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 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 PATIENTS

Our medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to www.mbc.ca.gov , email: licensecheck@mbc.ca.gov, or call (800) 633-2322.



I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT.

Patient Name

Signature

Date

Patient Representative Name/Relationship

Signature

Date

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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

Prescription drugs:

Non- prescription (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 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