A.J.KHALIL, M.D.
PLASTIC AND RECONSTRUCTIVE SURGEON

## DEMOGRAPHIC INFORMATION

Today's Date:_____

First Name:_____

Last Name: _____

Date of Birth: _____Age:_____

Email:_____

Social Security Number:_____

Home Address_____

City:_____State:_____Zip:_____

Home Phone Number:_____

Cell Phone Number:_____

Work phone Number:_____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widow

Spouse Name:_____

Spouse Phone Number:_____

Emergency Contact Name: _____

Emergency Contact Number: _____

Relation:_____

Occupation:_____

Employer:_____

Insurance Company:_____

Insurance Plan:_____

Insurance Phone Number :_____

InsurancePolicyNumber:_____

**HOW DID YOU HEAR ABOUT DR. KHALIL? ( PLEASE CHECK ALL THAT APPLY)**

☐ Social Media ☐ Google/Yahoo ☐ 1-800 My Surgeon ☐ Paper/Ad

☐ Smart Plastic Surgery.com ☐ Looking your best.com

☐ Gyneocomastia.org

☐ Friend If so please name:_____

☐ Patient If so please name:_____

☐ Family Member If so please name:_____

May we thank them? ☐ Yes ☐ No

**WHICH PROCEDURES ARE YOU INTERESTED IN? (Please check all that apply)**

☐ **BREAST ENHANCEMENT**
(Breast Augmentation, Breast Lift, or Breast Reduction)

☐ **TUMMY TUCK / ABDOMINOPLASTY**
(Removal of excess skin and fat of the abdomen)

☐ **LIPOSUCTION / LIPOSCULPTURE**
(Minimally invasive removal of localized fat deposits)

☐ **MALE BREAST REDUCTION / GYNECOMASTIA**
(Removal of excess fat and breast tissue from the chest)

☐ **FACE LIFT / NECK LIFT / MIDFACE LIFT**
(Tightening of skin and muscles of the face and neck)

☐ **EYELID LIFT**
(Removal of excess skin and fat from the eyes)

☐ **EYEBROW / FOREHEAD LIFT**
(Lifting of the eyebrow through minimal incisions)

☐ **RHINOPLASTY / SEPTOPLASTY**
(Reshaping and straightening of the nose to improve breathing)

☐ **FACIAL IMPLANTS**
(Augmentation of the chin or cheek with implants)

☐ **ARM LIFT**
(Removal of excess skin and fat of the arms)

☐ **THIGH LIFT**
(Removal of excess skin and fat of the thighs)

☐ **BUTTOCK AUGMENTATION**
(Enhancement of the buttocks with implants or fat)

☐ **BOTOX®**
(To soften the wrinkles around the eyes and forehead)

☐ **RESTYLANE® / JUVÉDERM® / RADIESSE®**
(Fillers to improve the deeper wrinkles of the face)

☐ **Other** Please Specify _____

**WHEN DO YOU WISH TO HAVE YOUR PROCEDURE?**

☐ **ASAP** ☐ **Within 1 month** ☐ **1-3 Months** ☐ **Not Sure**

**AUTHORIZATION/ASSIGNMENT:** I understand that I am financially responsible for all charges, whether or not covered by my insurance company. Furthermore, I permit payment directly to **A.J KHALIL, MD. INC**. for any benefits due or services rendered.

**MEDICAL RECORDS:** Authorization is hereby granted for release of any information required to process this claim. A copy of this authorization is as valid as the original. Authorization is hereby granted for release of the pertinent information (this may include photographs, operative notes, clinic and consultation notes) to a hospital/another physician's office for appropriate continuum of care treatment as required.

**Privacy Policy:** I acknowledge I have been offered a copy of **A.J KHALIL, MD, INC.'s** notice of privacy practices.

Signature: _____ Date:_____

436 N. Roxbury Drive, Suite 207, Beverly Hills, CA 90210 |T.310.385.8601|F.310.492.9974 |www.DrKhalilMD.com

A.J.KHALIL, M.D.
PLASTIC AND RECONSTRUCTIVE SURGEON

## MEDICAL HISTORY:

**Height:**_____ **Weight:**_____

**Family Physician**_____

**Address/Phone #:**_____

_____

**Do You Have Any of the Following Conditions? ( Please check all that apply):**

☐ Headaches ☐ Strokes ☐ Seizures ☐ Fainting Spells ☐ Heart Disease
☐ High Blood Pressure ☐ Chest Pain ☐ Shortness of Breath ☐ Lung Disease
☐ Thyroid Disease ☐ Liver Disease/Hepatitis ☐ Ulcers ☐ Anemia
☐ HIV ☐ Bleeding Problems ☐ Blood Clots
☐ Family/ Personal History of problems with Anesthesia

**Do you have any medical problems/conditions? (Please list below):**

_____

**SOCIAL HABITS:**
Cigarette Smoking ☐ Yes ☐ No ___# of cigarettes/day
Alcohol Use ☐ Yes ☐ No ___# of drinks/week
Drug Use ☐ Yes ☐ No

**FOR WOMEN ONLY:**
# of Pregnancies_____ Age of youngest child_____
Did you breast feed_____
Do you have any family or personal history of breast cancer?
_____
Date of last mammogram _____Results_____

**Have You Ever Had Surgery Before? ( Please List Below):**

Type/Date_____

Type/Date_____

Type/Date_____

**List any medications you take on a regular basis (including appetite suppressants, vitamins, herbal supplements, or any homeopathic medication)**

Name/Dosage_____

Name/Dosage_____

Name/Dosage_____

**Do you have any allergies to medications:**

Name/Reaction_____

Name/Reaction_____

Name/Reaction_____

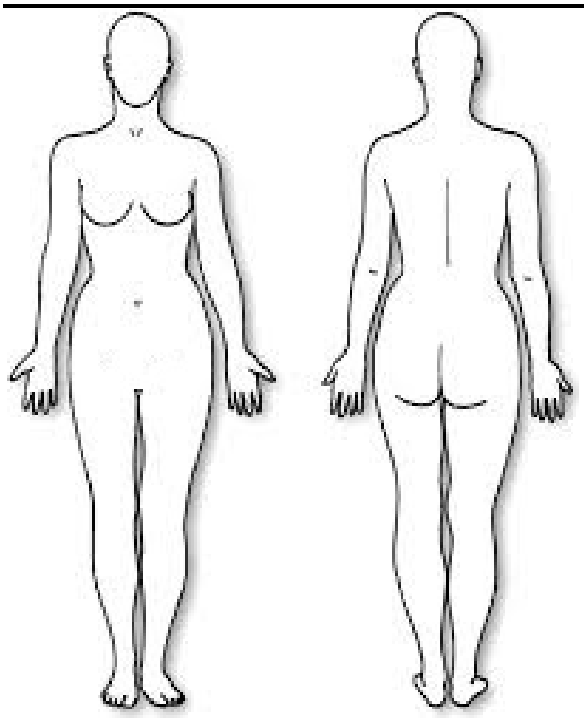
## DOCTORS NOTES:

## SURGICAL PROCEDURE(S):

1. Procedure/Plan Time:
_____
_____
_____
$ ESTIMATE_____

2.Procedure/Plan Time:
_____
_____
_____
$ ESTIMATE_____

3.Procedure/Plan Time:
_____
_____
_____
$ ESTIMATE_____



436 N. Roxbury Drive, Suite 207, Beverly Hills, CA 90210 |T.310.385.8601|F.310.492.9974 |www.DrKhalilMD.com