ANN ARBOR
PLASTIC SURGERY

2320 Washtenaw Ave. Ste A
Ann Arbor, MI 48104
734.913.5100

900 East Michigan Ave. Ste108
Jackson, MI 49201
517.789.9800

# Surgical Registration Form

Last Name:_____ First Name: _____ Middle Initial: _____

DOB: _____ Social Security #: _____

Address: _____ City/State/Zip: _____

Phone (Mobile/Home): _____ Email: _____

How did you hear about us? Yelp ☐ Friend/Family ☐ Website ☐ Other:_____

Have you had previous consultations? yes no If yes, date of prior consult: _____

**Please circle your areas of interest:**

| | | | |
|---|---|---|---|
| Breast Augmentation | Breast Lift | Liposuction | Rhinoplasty (Nose) |
| Tummy Tuck | Facelift | Facial fat grafting | Brow Lift |
| Eyelid Surgery | Hair restoration | Neurotoxin (Botox) | Dermal fillers (Juvederm) |
| Laser IPL (photofacial) | Laser hair removal | CoolSculpting | Ultherapy |
| Skin care/peels | Microneedling | Other: _____ | |

***COSMETIC PROCEDURES ARE ELECTIVE AND WILL NOT BE BILLED TO INSURANCE. IF YOU ARE VISITING TODAY FOR A NON-COSMETIC PROCEDURE PLEASE COMPLETE INSURANCE INFORMATION BELOW.***

Primary Insurance: _____ Secondary Insurance: _____

Name (Policy Holder): _____ Name (Policy Holder): _____

SS# _____ SS# _____

DOB of Policy Holder _____ DOB of Policy Holder _____

**MEDICAL HISTORY:**

Age:_____ Height: _____ Weight: _____

Reason for visit: _____

**Have you ever had any of the following or issues with? (Please circle yes or no)**

| | | | |
|---|---|---|---|
| Abnormal bleeding | yes no | Diabetes | yes no |
| Abnormal clotting | yes no | Heart problem | yes no |
| Acid regurgitation | yes no | Hypertension | yes no |
| Asthma | yes no | Hepatitis | yes no |
| Alopecia | yes no | Sleep Apnea | yes no |
| Anemia | yes no | Snoring | yes no |
| Angina | yes no | Tested positive for HIV | yes no |

List any medical problems (if none, please list n/a):

_____

_____

List previous surgeries (if none, please list n/a):

_____

_____

List current medications (if none, please list n/a):

_____

_____

List any drug allergies (if none, please list n/a), if yes, please list drugs and reaction:

_____

_____

**Have you ever had any of the following allergies or issues with? (Please circle yes or no)**

| | | | |
|---|---|---|---|
| Regular ibuprofen use | yes no | Latex allergy | yes no |
| Regular aspirin use | yes no | Tape allergy | yes no |
| Reaction to lidocaine/epinephrine | yes no | | |

**FAMILY HISTORY:**

| | | | | | |
|---|---|---|---|---|---|
| Abnormal bleeding | yes no | Coronary surgery | yes no | Kidney disease | yes no |
| Abnormal clotting | yes no | Diabetes | yes no | Tuberculosis | yes no |
| Anesthetic problems | yes no | Heart attack | yes no | Other serious illness | yes no |
| Cancer | yes no | Hypertension | yes no | | |

Please describe any question answered "yes" from the above family history information:

_____

_____

**SOCIAL:**

Smoker?: yes no if yes, amount/day: _____ Alcohol_____/week

Married?: yes no Occupation: _____ Employer: _____

**REVIEW OF SYSTEMS:**

| | | | |
|---|---|---|---|
| Bladder/bowel dysfunction | yes no | Immune system problems | yes no |
| Blood clots | yes no | Irregular heartbeat | yes no |
| Breast cancer | yes no | Seizures | yes no |
| Blurred/double vision | yes no | Shortness of breath | yes no |
| Cold sores/recent fever | yes no | Walking/balance problems | yes no |
| Currently pregnant | yes no | Vomiting | yes no |
| Depression/psychiatric treatment | yes no | | |

**FEMALE PATIENTS ONLY:**

Date of last menstrual cycle: _____ Date of last mammogram:_____, n/a

Birth control: yes no Did you Breastfeed? yes no n/a

## Confidential Communication Request Acknowledgement of Receipt of Notice of Privacy Practice

As required by the Health Information Portability and Accountability Act you have the right to request the communications concerning your personal health information be made through confidential channels. This medical practice will make reasonable efforts to accommodate all reasonable requests.

I, _____ (print name) request the following channels for communication.

**Emergency Contact Information**:

May we discuss information with anyone else? yes no If yes, please list name and relationship below:

1. Name: _____ Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone: _____
3. Name: _____ Relationship: _____ Phone: _____

By signing below, I authorize my health information, medical record or protected health information, financial records, to be used or disclosed at my request to the above named, Ann Arbor Plastic Surgery staff, financial insitutions, and my primary/referring physician.

I acknowledge that I have been presented with a copy Malhotra Center for Plastic Surgery d/b/a Ann Arbor Plastic Surgery Notice of Privacy Practices.

Print Name: _____
Patient Signature: _____ (if minor/disabled - legal guardian signature)
Date: _____

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## Assignment of Benefits and Financial Responsibility

If applicable I request that payment of authorized Medicare commercial insurance, or be made to Dr Malhotra of Ann Arbor Plastic Surgery, PC for services provided to me. I authorize medical information to be released to the Centers for Medicare, or private health insurance carrier to determine these benefits.

We render services on the assumption that your charges may not be paid by your insurance company. If you have any questions, we suggest that you receive advance confirmation from your insurance company.

The patient (or responsible party) is advised and agrees: That the full amount of (their) fees, costs and expenses for COSMETIC SURGERY are due and payable 3 weeks before surgery, and that patients will incur additional costs for revision or touch up surgery. Patients who cancel surgery for non-medical reasons will lose their fees. Returned checks will be assessed a $50.00 NSF fee. ***No Shows***: Patients must cancel their appointments in advance if they cannot attend, otherwise their account will be billed a $50.00 "no show" charge.

I realize that all medical and surgical charges incurred by me or my dependents for services rendered are my financial responsibility.

Print Name: _____
Patient Signature: _____ (if minor/disabled - legal guardian signature)
Date: _____

**Patient Photography Consent**

Patient Name: _____ (Please Print)

***We do not release photos and/or videos to patients. Please take your own photos if you wish to follow your results.***

I consent to the taking of photographs and/or videos by Dr. Pramit S. Malhotra or his designee of me in connection with the procedure(s) to be performed . I further authorize Dr. Pramit S. Malhotra to release to the American Society of Plastic Surgeons® ("ASPS®") or Allegiance Health such photographs and/or videos. I hereby also grant permission for the use of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination, testing, credential ing and/or certifying purposes by the American Board of Plastic Surgery, Inc. and Allegiance Health.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs and/or videos shall become the property of Dr. Pramit S. Malhotra and may be retained or released by Dr. Pramit S. Malhotra for the purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, websites, patient demonstration purposes for the purpose of informing the medical profession, the general public, and prospective patients about plastic surgery procedures.I understand the photographs and/or videos may portray features that will make my identity recognizable.

I understand I may refuse to authorize the release of any health information, but will not affect the health care services I receive. I understand I may inspect and copy the information that I have authorized to be disclosed and to revoke this authorization in writing at any time. I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because Dr. Pramit S. Malhotra is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HlPAA.

I release and discharge Dr. Pramit S. Malhotra, ASPS, and all parties acting under their license and authority from all rights and claims that I may have in the photographs and/or videos and relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs and/or videos.

I understand that the doctor-patient relationship is a bond of trust and mutual respect that ethically and legally precludes Dr. Malhotra from disclosing information about me without my permission. Therefore, I too, agree not to disclose any information regarding the care I received from him without his permission. If a patient does prepare commentary for publication about the Doctor, the patient exclusively assigns all Intellectual Property rights, including copyrights, to Doctor for any written, pictorial, and/or electronic commentary.

Patient and Doctor acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, patient and Doctor agree to the right of equitable relief (including but not limited to injunctive relief). Ann Arbor Plastic Surgery collects email addresses for marketing purposes. We may use your email to extend special offers by us or third parties.

I certify I have read the above Authorization and Release and internet posting policy and understand its terms.

Signature:_____Date_____

_____

***If you want your photos used for *medical records ONLY* Sign Here:** _____

I have read the above consent. I am the parent, guardian, or conservator of_____, a minor. I am authorized to sign this authorization on his/her behalf and give this authorization.

Signature: _____ Date: _____