

Surgical Registration Form

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

Address: _____ City/State/Zip: _____

DOB: _____ Phone (Mobile): _____

Email: _____

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

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	Heart problem	yes no
Abnormal clotting/DVT	yes no	Hypertension	yes no
Acid regurgitation	yes no	Hepatitis	yes no
Asthma	yes no	Sleep Apnea	yes no
Anemia	yes no	Snoring	yes no
Diabetes	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	Other serious illness	yes no
Anesthetic problems	yes no	Heart attack	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

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.

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: _____

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 and Balance Medical staff, financial institutions, 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 and Balance Medical Notice of Privacy Practices.

Assignment of Benefits and Financial Responsibility

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. This practice will provide a good faith estimate before any surgical procedure.

No Shows: Patients must cancel their appointments 24 hours 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. Take your own photos if you wish to follow your results.

This photo consent applies to any and all services rendered by Prमित Malhotra MD, Tiffany Ballard MD, Pierre Lapaine MD, and all providers associated with Ann Arbor Plastic Surgery, Balance Medical.

I consent to the taking of photographs and/or videos by Ann Arbor Plastic Surgery, Balance Medical or his designee of in connection with the procedure(s) to be performed . I further authorize Ann Arbor Plastic Surgery, Balance Medical 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, credentialing 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 Ann Arbor Plastic Surgery, Balance Medical and may be retained or released by Ann Arbor Plastic Surgery, Balance Medical for the purpose of including them in any print, visual or electronic media, social 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 Ann Arbor Plastic Surgery, Balance Medical 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 HIPAA.

I release and discharge Ann Arbor Plastic Surgery, Balance Medical, 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 ONLY want my photos used for medical records only:

Signature: _____ Date: _____

I CERTIFY that I have read the above Authorization and Release and interne, social media posting policy and agree to its terms.

Signature: _____ Date: _____

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: _____