ANN ARBOR
PLASTIC SURGERY

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
Abnormal clotting/DVT yes no
Acid regurgitation yes no
Asthma yes no
Anemia yes no
Diabetes yes no
Heart problem yes no
Hypertension yes no
Hepatitis yes no
Sleep Apnea yes no
Snoring 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? (Please circle yes or no)

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

FAMILY HISTORY:

Abnormal bleeding yes no
Abnormal clotting yes no
Anesthetic problems yes no
Cancer yes no
Coronary surgery yes no
Diabetes yes no
Heart attack yes no
Hypertension yes no
Kidney disease yes no
Other serious illness 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
Blood clots yes no
Breast cancer yes no
Blurred/double vision yes no
Cold sores/recent fever yes no
Currently pregnant yes no
Depression/psychiatric treatment yes no
Immune system problems yes no
Irregular heartbeat yes no
Seizures yes no
Shortness of breath yes no
Walking/balance problems yes no
Vomiting 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, Privacy Acknowledgement, and Financial Responsibility

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), you have the right to request that communications regarding your protected health information be provided through confidential channels. We will make reasonable efforts to accommodate all reasonable requests.

Authorized Contacts

May we discuss your care and account information with anyone else? Yes / No

If yes, please provide:

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

By signing below, I authorize Ann Arbor Plastic Surgery and Balance Medical to disclose, at my request, relevant health information, medical records, protected health information, and financial information to the individuals listed above, appropriate practice staff, financial institutions, and my primary care or referring physician, as applicable. I also acknowledge that I have received a copy of the Notice of Privacy Practices for Malhotra Center for Plastic Surgery d/b/a Ann Arbor Plastic Surgery and Balance Medical.

Financial Responsibility

I understand and agree that all fees, costs, and expenses related to cosmetic surgery are my personal responsibility and are due in full no later than three (3) weeks before surgery. I understand that revision or touch-up procedures may result in additional charges. If surgery is canceled for non-medical reasons, applicable fees may be forfeited in accordance with practice policy. Returned checks are subject to a $50 non-sufficient funds fee. A good-faith estimate will be provided before any surgical procedure, as required.

Appointment and No-Show Policy

We kindly request at least 24 hours' notice for any appointment cancellation. Missed appointments or cancellations made with less than 24 hours' notice may result in a $50 no-show fee.

By signing below, I acknowledge that I am financially responsible for all medical and surgical charges incurred by me or my dependents for services rendered by this practice.

Print Name: _____

Patient Signature: _____ (If patient is a minor or unable to sign, legal guardian signature)

Date: _____

Patient Photography Consent

Patient Name (Please Print:)_____

Note: We do not release photos and/or videos to patients. Please take your own personal photos to follow your results.

This photo consent applies to all services, and all providers, rendered by Malhotra Center for Plastic Surgery dba, Ann Arbor Plastic Surgery and Balance Medical

03/2026

I consent to the taking of photographs and/or videos by Ann Arbor Plastic Surgery, Balance Medical, Balance Hair Restoration or its designee in connection with the procedure(s) to be performed.

I provide this authorization as a voluntary contribution and I understand that such photographs and/or videos shall become the property of Ann Arbor Plastic Surgery and Balance Medical and will be retained or released by Ann Arbor Plastic Surgery and/or 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, 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 this 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 and 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 HlPAA.

I release and discharge Ann Arbor Plastic Surgery, Balance Medical, and 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 all providers associated with Ann Arbor Plastic Surgery and Balance Medical from disclosing information about me without my permission. Therefore, I 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 the provider 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 and Balance Medical collects email addresses for marketing purposes. We may use your email to extend special offers by us or third parties.

I have read, understand, and agree with this consent and enter it voluntarily.
Signature:_____Date:

Opt-Out - Medical Records ONLY: I agree with the above but want my photos only used for my medical chart.
Signature:_____Date:

Minor Consent ONLY:
Sign below if you are the parent, guardian, or conservator of a minor and authorized to sign this on his/her behalf.
Signature:_____Date: