

CONSENT FOR OFFICE SURGERY

FOUR POINTS



DERMATOLOGY

Patient: _____ DOB _____ Today's Date: _____

- 1. I hereby authorize Dr. Roopal Bhatt to perform the following medical treatment, operation, and/or surgical procedure(s): _____
- 2. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made or implied to me as to the results or the operation or permanency of the results or my satisfaction with the results.
- 3. I understand that there will be permanent scars where incisions have been made.
- 4. It has been explained to me that a satisfactory result is expected but that the following are some of the complications or effects that could or may occur: Bleeding, infection, damage to adjacent tissues or structures, swelling, pain, suture reaction, delayed healing, scarring, anesthesia or medication reaction, recurrence, additional operations, numbness, or scar formation.
- 5. I consent to the administration of anesthesia and to the use of such anesthetics as may be deemed necessary or desirable by the physician.
- 6. I agree to keep the above-name surgeon informed of any change of address and I agree to cooperate with her in my care after surgery until completely discharged.
- 7. I also understand that scars may be permanent and do heal in an unpredictable fashion. I have been told of the position of the scars, the length of the scars, and the possibility of concealment in the future. (If a revision surgery is necessary, the patient will be charged if deemed necessary).
- 8. All possible options regarding treatment for this condition have been reviewed and discussed with me and I fully understand these options.
- 9. I understand that the above-name surgical, medical, and/or diagnostic procedures are planned for me, and I voluntarily consent and authorize these procedures.
- 10. I understand that a biopsy or excision (cut out area) will be sent to laboratory for specific diagnosis (**laboratory will issue a separate bill**).

Please check the appropriate box corresponding to any personal medical history.

Do you have a history of:

Pacemaker/Defibrillator YES NO HIV or Hepatitis B/C..... YES NO Smoking..... YES NO

Fainting Spells..... YES NO Artificial Joints/Heart Valve(s) YES NO If yes, list date(s): _____

Change of medications since last visit.....YES NO If yes: _____

Are you taking blood thinners? (aspirin, coumadin, effient, plavix, aleve, alcohol, garlic, ginseng, ginger, ginkgo, ibuprofen, vitamin E or other herbals).....YES NO If yes: _____

I have read the above consent, filled out the appropriate medical histories, and acknowledge I am able to receive a copy of this consent if I wish. I understand the contents and have had the opportunity to ask questions concerning it. I hereby request and authorize the above-named physician to perform the above-noted surgery and/or procedure.

Print Name of Patient

Parent/Guardian or Healthcare Power of Attorney (*if necessary*)

Signature

Date

Signature

Date