

Dr. Stephen Dent, M.D.

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Encinitas, CA 92024
(760) 479-2100

I _____ do hereby give consent to Dr. Dent MD

to perform the following office procedure: _____

_____.

Dr. Dent has discussed with me the reasons and benefits of this procedure. I understand the outcomes with and without the procedure and have been discussed with me in detail. I further understand that any operation or procedure involve some risks and hazards. The more common risk include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions and severe blood loss.

I recognize that during the course of treatment(s) or procedure(s), unforeseen conditions may necessitate additional or different procedures or treatments than those set forth above. I, therefore, further authorize and request that my physician and the appropriate staff perform such procedures or treatments as are deemed necessary.

If any tissue, lesions or part is removed, the medical facility will send to pathology or dispose of it in accordance with the medical facilities usual custom.

I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantee, either expressed or implied, has been made as to the results of this procedure.

I understand these risks and consent for the above procedure.

Signature: _____ Date: _____

Print name: _____

Witness: _____