CONSENT FOR SOFT TISSUE BIOPSY PROCEDURE

Name: _____Date:_____

You have the right to be given pertinent information about your proposed surgery so that you may make an informed decision as to whether or not to proceed.

In your case, the area of concern is:_____

____1. I understand that a biopsy requires an incision(s) in my mouth or on the skin, which will require stitches. It has been explained that there are certain risks associated with the surgery, including (but not limited to):

- ____A. Post-operative discomfort and swelling that may require several days of at-home recuperation.
- ____B. Prolonged or heavy bleeding that may require additional treatment.
- ____C. Post-operative infection that may require additional treatment.
- ____D. Stretching of the corners of the mouth that may cause cracking and bruising and which may heal slowly.
- ____E. Restricted mouth opening for several days, sometimes related to swelling and muscle soreness and sometimes related to stress on the jaw joints (TMJ).
- ____F. Reactions to medications, anesthetics, sutures.
- ____G. Injury to sensory nerve branches in the area of the biopsy which may result in pain or tingling or numb feeling in the lip, chin, tongue, cheek, gums or teeth, or in areas of the skin of the face. Usually this disappears slowly over several weeks or months, but occasionally the effects may be permanent.
- ____H. Other:_____

____2. It has been explained to me that during the course of surgery unforeseen conditions may be revealed which may necessitate extension of the original procedure or a different procedure from that planned. I authorize my doctor to perform such additional procedures as are necessary in the exercise of professional judgment.

____3. The anesthetic I have chosen for my surgery is:

- ___Local anesthetic
- ___Local with intravenous sedation
- ___General anesthesia

____4. I understand that I may be given appointments for long-term follow-up care after my surgery. I recognize the importance of returning for such follow-up which, if not done, may allow progression of my condition to a state requiring additional care. I agree to comply by regularly scheduling exams as instructed and to notify this office if I suspect a change in my condition.

____5. I understand that no guarantee can be promised and I give my free and voluntary consent for treatment. My signature below signifies that all questions have been answered to my satisfaction regarding this consent and fully understand the risks involved in the proposed surgery and anesthesia. I certify that I speak, read and write English.

Patient's (or Legal Guardian's signature)	Date
Doctor's signature	Date
Witness's signature	Date