Medical Procedure Consent Form

Date: ____________________

Patient Name: ____________________

Date of Birth: ____________________

Procedure: ____________________

Consent to Treatment

I, the undersigned, consent to the performance of the above-mentioned procedure by Dr. ____________________ and his/her associates. I understand that the procedure involves certain risks, including but not limited to:

- Infection
- Bleeding
- Allergic reactions
- Complications related to anesthesia

Alternatives

I have been informed of the alternative treatments available and the risks involved with those options.

Recovery and Follow-Up

I understand that there may be a follow-up appointment scheduled and I will adhere to the post-procedure instructions provided.

Patient Acknowledgment

I acknowledge that I have had the opportunity to ask questions regarding this procedure and my questions have been answered to my satisfaction.

Signature of Patient: ____________________

Signature of Guardian (if applicable): ____________________

Date: ____________________

Witness: ____________________