

Patient Consent Form for Laser Eye Treatment

Date: _____

Patient Name: _____

Patient ID: _____

Procedure Information

I, the undersigned, hereby give my consent to undergo laser eye treatment as discussed with my healthcare provider. I understand that this procedure involves the use of laser technology to correct my vision.

Risks and Benefits

I have been informed about the potential risks and benefits associated with laser eye treatment, including but not limited to:

- Possible side effects such as dry eyes, glare, and halos.
- Potential need for further treatments.
- Possible complications.

I understand that results can vary and that my healthcare provider cannot guarantee specific outcomes.

Confirmation of Understanding

I confirm that I have had the opportunity to ask questions regarding the procedure, and I feel adequately informed to make an educated decision about my treatment.

Consent

I hereby give my consent to proceed with the laser eye treatment.

Patient Signature: _____

Date: _____

Witness

Witness Signature: _____

Date: _____