

Medical Procedure Consent Form

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Procedure Details

Procedure Name: _____

Scheduled Date: _____

Consent Statement

I, _____, hereby give my consent for the above-mentioned medical procedure to be performed by Dr. _____ and their medical team.

I understand the nature of the procedure, the potential risks and benefits, and that I have the right to ask questions and receive answers regarding the procedure.

Patient Agreement

I confirm that I am of sound mind and am making this decision voluntarily. I have had the opportunity to discuss my medical history and current medications with my healthcare team.

Signatures

Patient Signature: _____

Witness Signature: _____

Date: _____

Contact Information

If you have any questions, please contact our office at: [Phone Number] or [Email Address].