Procedure Consent Form

Patient Name

First Name

Last Name

Date

MM-DD-YYYY

Date

Email

example@example.com

Phone Number

(000) 000-0000

Please enter a valid phone number.

Address

Street Address

City

State / Province

Postal / Zip Code

My Doctor's Name

First Name

Last Name

My doctor has explained to me that the following condition(s) exist in my case:

Type here...

I understand that the procedure proposed for evaluating and treating my condition is/are:

Type here...

Just as there may be benefits to the procedure(s) proposed, I also understand that medical and surgical procedures involve some risks. These risks include allergic reaction, bleeding, blood clots, infections, adverse side effects of drugs, and scarring.

I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed procedure(s) unforeseen

I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.

Having read this form and talked with the physicians, my signature below acknowledges that I voluntarily give my authorisation and consent to the performance of the procedure(s) described above by my physician and/or his/her associates assisted by medical centre personnel and other trained persons as well as the presence of observers.

Date

MM-DD-YYYY

Date

Patient Signature

Clear

Submit