SMG Novacare Medical

Informed Consent for Minor Surgical Procedures

Patient Name: _____ Patient DOB: _____ Account #:___

Date: _____ Office Location: _____

I am providing Dr._____ permission to perform the following minor surgical procedure on me or my minor child _____.

- ❑ Wart Removal
- ❑ Mole Removal
- ❑ Skin Lesion Removal
- ❑ Other (List the procedure) _____

I understand that some numbing medication may be used, but I may still feel some pain during and after the procedure. I understand that risks of the procedure may include bleeding, scarring, or infection. My physician has discussed the following additional risks:

_____
_____
_____
_____

I have discussed the alternative treatment options with my physician and also understand I may choose not to have the procedure performed.

I have had an opportunity to have my questions answered.

By signing this form, I understand the risks, benefits and alternatives of the minor surgical procedure and agree to proceed.

Patient Signature: _____ Date: _____

Relationship, if not patient: _____

Provider Signature: _____