Dermatology Procedure Consent Form

Patient Name:

Date of Birth:

Procedure Name:

Physician Name:

Date of Procedure:

Consent

I hereby acknowledge that my physician has explained the nature, purpose, benefits, and possible risks and complications of the above dermatology procedure. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction.

Risks and Complications Discussed:

Alternative Treatments Discussed:

Questions/Concerns from Patient:

By signing below, I acknowledge that I have read and understood the information provided above and consent to the procedure.

Patient Signature:

Date:

Physician Signature:

Date: