DR. JAMES ARONOVITZ | Hair & Facial Plastics INSTITUTE

OFFICE PROCEDURE CONSENT FORM

Patient's Name _____ Date of Birth _____

I consent to and authorize James H. Aronovitz, D.O. to perform the following procedure on above named patient:

Dr. Aronovitz has explained the following to me to my complete satisfaction:

1. The nature and purpose of the procedure/ surgery.
2. The possible alternative methods of treatment.
3. The risks involved and the possibility of complications.
4. Information regarding the use and purpose of the local anesthesia.
5. The risks involved with and the possible complications associated with the use of local anesthesia.

_____	_____	_____
Signature of Patient/Guardian	Date	Time
_____	_____	_____
Signature of Physician	Date	Time
_____	_____	_____
Signature of Witness	Date	Time