SURGICAL CONSENT FORM
NIGRO DERMATOLOGY GROUP, PA

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The surgical procedure or treatment to be performed is: _____
_____

I, _____ consent to have the above mentioned surgical procedure or treatment. The procedure has been explained to me. I understand the possible risks: including:

Pain Bleeding Infection Persistent redness
Scar formation (which can sometimes look worse than the original lesion)
Increase or decrease of my skin pigmentation
Recurrence of lesion
Local nerve damage or numbness
Severe allergic reaction to the local anesthesia, dressing or medications

I understand there may be other ways to do this procedure, but agree to the procedure about to be done, understanding all risks. I have been given the opportunity to ask all questions regarding the procedure and its risks. I understand that specimens may be sent for microscopic evaluations.

I consent to this elective procedure.

_____ _____
Patient's Signature **Guardian's signature, if applicable**

_____ _____
Date **Witness**