Informed Consent Soft Tissue

ATLANTIC
Oral Surgery & Facial Reconstruction Centres

1. I, _____, hereby consent to the following procedure or operation _____
   To be performed upon myself by Dr. and his staff at Atlantic Oral Surgery Associates or such consultants or employees of said facility as required for the _____ operation or procedure.

2. The anticipated nature and effect of such procedure/operation has been explained to me with the potential risks as follows; bleeding, bruising, infection, scarring, necrosis, numbness or other side effects not listed here.

3. I also consent to such additional or alternative investigative, operation or treatment procedures including intraoperative photography as many are found to be immediately necessary during the course of such procedure/operation and to the administration or there anesthetics for any of these purposes.

4. I further agree to the retention by Atlantic Oral Surgery Associates for the purpose or study and diagnosis of any tissue that may be removed during the investigative procedure/operation.

5. Restriction to this consent:_____
   _____

I confirm that I have explained the nature and mention the effect of the above procedure/operative to the patient or guardian.

Patient's (or Legal Guardian's) Signature Date:

Witness' Signature Date: