Elective Surgery Consent Form

Patient Name: _____

Date of Birth: _____

Procedure: _____

Treating Physician: _____

Consent Statement

I hereby authorize Dr. _____ and his/her associates to perform the procedure listed above. The risks, benefits, and alternatives have been explained to me. I understand that complications may arise and that no guarantee has been made as to the outcome of the procedure.

☐ I acknowledge that I have discussed and understood the potential risks and benefits.

Signature of Patient: _____

Date: _____

Witness Name: _____

Witness Signature: _____

Date: _____