BIOPSY

AUTHORIZATION AND CONSENT TO BIOPSY WITH LOCAL ANESTHESIA

1. I understand that due to the type of lesion I have, the doctor has recommended that I undergo a biopsy, which is a procedure in which a portion of the lesion will be removed. The expected result of this procedure is to adequately diagnose the lesion type.

2. I understand that risks of the recommended treatment include, but are not necessarily limited to: (a) allergic or other reactions to the local anaesthetic or other medications used, (b) swelling and/or infection, (c) pain and/or thermal sensitivity, (d) temporary restricted mouth opening, (e) need for another biopsy and (f) scarring.

3. I understand that in the course of the biopsy, it may become necessary to perform additional procedures which are not known to be needed at this time. I request that hereby provide my informed consent to the doctor to perform such procedures at their discretion, if needed during the biopsy.

4. I understand that the performance of diagnostic studies relating to my biopsy will be performed by other medical/dental professionals.

5. I consent to photography, video recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications, provided my identity is not revealed.

6. I CERTIFY THAT I HAVE READ FULLY AND HAVE HAD ALL MY QUESTIONS ANSWERED SATISFACTORILY SO THAT I UNDERSTAND THE ABOVE CONSENT TO TREATMENT BEFORE HEREBY SIGNING.