San Dimas Family Practice
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INFORMED CONSENT FOR PROCEDURE

Patient:_____ Date:_____
(Print name of Patient)

I hereby give my consent and authorize Kavitha Kotrappa, MD and San Dimas Family Practice to treat the following condition(s):

_____

The provider has explained my condition to me, the above treatment procedure and alternative methods of treating my condition.

The provider has explained to me that this procedure has minimal risks involved.

Risks associated with this procedure may include the following: allergic reaction to the medications, small amount of bleeding from the surgical site, discomfort or minimal pain at the surgical site, dizziness or lightheadedness during or after the procedure, Infection in the tissues after the procedure

Should I have questions or experience bleeding or signs of infection, I know I can call the office.

I consent to the administration of local anesthesia as most appropriate for the above procedure.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All of my questions have been adequately answered.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian *Relationship to Patient*