



**CONSENT FOR LIP LIFT PROCEDURE Page 1 of 1**

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

\_\_\_\_ 1. This is my consent for Dr. Niamtu and staff who is working with him/her to perform the following treatment/procedure/surgery \_\_\_\_\_.

\_\_\_\_ 2. Lip shortening procedure involves removing strip of skin under the nose which will shorten/plump the lip and slightly increase amount of front teeth shown when smile and/or relaxed.

\_\_\_\_ 3. I understand that although unusual, a permanent scar may be visible. I also understand that there can be a chance of hyperpigmentation, hypopigmentation at the incision, scar, and under or over correction which may need revision surgery and motor or sensory nerve damage which may be temporary or permanent. I also understand that oral function such as puckering and smiling may be affected during the healing period. I also understand that it is difficult to reverse this procedure.

\_\_\_\_ 4. I understand that this procedure will allow more of my upper teeth to show and although rare it is possible that this amount of upper front tooth exposure could significantly greater than before the surgery.

\_\_\_\_ 5. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction.

\_\_\_\_ 6. I certify that I have had an opportunity to read and fully understand the terms within the above consent and the explanation made, and that all blanks or statements requiring completion were filled in and any applicable paragraphs were stricken before I signed. I also state that I speak, read and write English.

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

Witness' Signature	Date
--------------------	------

Surgeons' Signature	Date
---------------------	------