



CONSENT FOR LASER SKIN RESURFACING

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Patient's Name	Chart#	Date
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I have been informed that I have the following condition(s) _____

The procedure(s) to treat my condition(s) has/have been described to me as laser skin resurfacing of _____

I have been told of the following treatment options, and the risks and benefits of each have been explained:

1. No treatment
2. Use of make up
3. _____

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

I have been told and understand that:

- ___ 1. Laser skin resurfacing is a process by which laser light is applied to the skin of the face in an attempt to change the appearance of lines, wrinkles, skin blemishes, scars and certain other localized skin conditions. Laser skin resurfacing will neither stop the aging process nor totally eliminate wrinkles. The final result of treatment may not be apparent for several months. Future treatment may be necessary, depending upon the success of this initial treatment.
- ___ 2. Treated areas will have a reddish appearance that can persist for several weeks to a number of months, but is rarely permanent. At the junction between treated and untreated areas and predominantly at the junction of the face and neck, a different skin color or blotching may occur. The texture of the skin may be permanently altered. Deep areas of skin wrinkling may be minimized or softened, but not eliminated. Areas of deep skin scarring (usually from acne) may require additional resurfacing treatment.
- ___ 3. The risk of infection is rare, but should it occur, topical and/or systemic antibiotic therapy may be necessary.
- ___ 4. Laser skin resurfacing usually causes some discomfort and swelling. Oozing typically occurs and the area may become covered with a crust that will normally separate within a few weeks. A skin dressing may be applied to aid in healing. If no dressing is used, it will be necessary to clean the resurfaced area 4-5 times daily and to keep the area covered with prescribed medications or ointments. Failure to do so may have negative effects on healing and the final result of surgery.
- ___ 5. Hyperpigmentation (the color of the treated areas becomes darker than the surrounding skin) is the most common side effect. Certain medications may be prescribed or recommended to help minimize this effect. Hypopigmentation (lightening of the skin color) is a rare complication. Both of these pigment

complications usually fade in 6-12 months; however, they may be permanent. Please inform your doctor if you have used Accutane within the past year, or if you have ever had cold sores or other blister lesions on your face.

- ___ 6. Scarring, although rare, is a possible complication. The scars may be hypertrophic scars that are thickened scars, and/or keloid scars that are abnormal, raised scars that may extend beyond the limits of the original scar.
- ___ 7. After a laser procedure, minor surgical revisions may be required. A surgical fee will be charged commensurate with the extent of the revision.
- ___ 8. There is a risk of eye injury from laser energy.
- ___ 9. Pre-existing hypopigmentation will not be corrected with laser surgery.

Additional Information:

- ___ 1. This is elective, cosmetic surgery and I understand that results may vary due to individual patient differences. It is possible that my skin condition may worsen and that selective re-treatment may be required. I realize there can be no guarantee that the proposed treatment will be curative (healing) or meet all aesthetic (sense of beauty) expectations.
- ___ 2. I have provided a full and truthful health and social history, including drug, alcohol and tobacco use. I understand that withholding information may delay healing and jeopardize the planned goals of surgery. I agree to cooperate fully with my doctor's recommendations while under treatment, realizing that lack of cooperation can increase risks and complications.
- ___ 3. If any unforeseen condition should arise during surgery that may call for additional or different treatment from that planned, I authorize my doctor to use professional judgment to provide appropriate care.
- ___ 4. I agree to avoid direct sunlight for two (2) months after treatment and to use sun block of at least SPF 30 for 6-12 months thereafter. I also agree to decrease alcohol and tobacco use as much as possible, recognizing their negative effect on healing.
- ___ 5. I realize that my new skin will be sensitive and it is in my best interest to take care of the new result with recommended products and treatments suggested by Dr. Niamtu and his staff. Abiding by this will extend my rejuvenation.

Female Patients

- ___ 1. I have advised my doctor as to whether or not I am currently utilizing birth control pills. I have been advised and informed that certain antibiotics and some pain medications may neutralize the therapeutic effect of birth control pills, allowing for conception and resulting in pregnancy. I agree to consult with

my family physician to initiate additional forms of mechanical birth control during the period of my treatment with my doctor until I am advised that I can return to the exclusive use of birth control pills by my physician.

Joe Niamtu, III, DMD Cosmetic Facial Surgery
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Consent

I certify that I have had an opportunity to read this entire consent, that all blanks were filled in before my signing, and that all my questions were answered to my satisfaction. I also certify that I read, speak, write and understand English. I also agree to the taking of photographs/video for scientific or educational purposes. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

Patient's (or Legal Guardian's) Signature

Date

Doctor's Signature

Date

Witness' Signature

Date