CONSENT FOR LIP SHORTENING

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.

____ 4. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction.

____ 5. Revision surgery, although rare, is a possibility with any cosmetic procedure. Post operative touch ups are usually minor and most often performed with local anesthesia. A surgical fee will be charged commensurate with the extent of the revision.

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

_____ _____
Surgeon's Signature Date