# CONSENT FOR BIOPSY

**Diagnosis**

After careful oral examination, my periodontist has advised me that I have a lesion in my mouth, which will need to be removed to adequately diagnosis the lesion type.

**Recommended Treatment**

In order to treat this condition, my periodontist has recommended that a biopsy be performed. The oral biopsy will involve the following steps:

- Administration of local anesthesia to numb the area
- Removal of a small sample, or the lesion entirely, of oral tissue using a scalpel, or other suitable instrument
- Application of pressure or sutures to control bleeding
- Placement of a protective dressing, if necessary
- Post operative instructions and information on follow-up appointments

**Expected Benefits**

The purpose of this procedure is to obtain a sample of oral tissue for further examination and analysis, and provide an accurate diagnosis of my oral health condition.

**Risks of Biopsy**

I have been informed that the oral biopsy procedure carries the following risks:

- Bleeding
- Swelling
- Discomfort or pain
- Infection
- Possible damage to nearby structures
- Numbness around the surgical area, and/or neighboring areas. Almost always the sensation returns to normal, but in rare cases, the loss may be permanent

I hereby certify that I clearly comprehend the nature, purpose, benefits, risks and alternatives to (including no treatment), the proposed procedure(s). I have been given the opportunity to ask questions and they have been answered to my complete satisfaction.

I authorize photos, slides, x-rays or any other viewing of my care and treatment during of after its completion to be used for advancement of dentistry and reimbursement purposes. However, my identity will not be revealed to the general public without my permission.

**Patient Name/Signature:_____ Date: _____**