

Patient Name: _____

Date of Birth: _____

Stuart M. Nunnally, D.D.S., M.S.
Lane B. Freeman, D.D.S.
Candice H. Owens, D.D.S.
G. Rich Dorsey, D.D.S.
T. Ken Etheredge, D.D.S.

Consent for Laser Surgery

I hereby do authorize treatment. I have read and understand this document in its entirety, outlining office policies and financial policies of Drs. Stuart Nunnally, Lane Freeman and Candice Owens.

- _____ Buccal Frenuloplasty
- _____ Lingual Frenuloplasty
- _____ Labial Frenuloplasty (upper and/or lower lip)
- _____ Biopsy
- _____ Operculectomy
- _____ Soft Tissue Remodeling
- _____ Fibroma Removal
- _____ _____

The nature and purpose of the procedure have been explained to me and no guarantee can be made about treatment outcome. I understand that I have the opportunity to inquire about alternative methods of treatment. I also consent to the administration of local anesthesia. (I understand that the administration of medications and the performance of surgery can carry certain common, inherent risks, or complications such as, but not limited to: bleeding, swelling, discomfort, paresthesia, numbness, nerve injury, nausea, infection and/or myofascial pain.) I agree to abide by the post-operative instructions and that my failure to properly care for my health may lead to further complications.

Print Name _____ Date _____

Signature _____