TIMOTHY L. GARDNER, D.P.M., P.C.
Consent to Operation

Patient's Name _____ **Date of Birth** _____

Date of Surgery _____ **Time** _____ **AM/PM**

1. I hereby authorize Dr. Gardner and whomever he may designate as his assistants to perform the following operation _____ on the left/right foot.
2. The nature and purpose of the operation, possible alternative methods of treatment, the risks involved, and the possibility of complications have been explained to me. I acknowledge that no guarantee has been made to me as to the results that may be obtained.
3. If any conditions are revealed to Dr. Gardner or any physician/assistant involved at the time of the procedure which were not recognized before the procedure started and which call for procedures in addition to those originally contemplated, I authorize the performance of such procedures in accordance with the judgment of Dr. Gardner or any physician involved.
4. I consent to the administration of anesthesia to be applied by or under the direction of Dr. Gardner and to the use of such anesthetics, as he may deem necessary.
5. I consent to the disposal and/or pathology, if needed, of any tissue and/or parts, which may be removed during the surgical procedure.
6. To the best of my knowledge I have not had an allergic reaction to any drug or mediation, except: _____.
7. I understand that the use of drugs, prescribed or otherwise, the abuse of same (both past and present) or the existence of medical conditions not disclosed by myself to Dr. Gardner or his assistants may affect his recommendation as to treatment or alternative forms of treatment and I assume all risks which may exist as a result of my failure of refusal to disclose such matters prior to treatment.
8. I certify that I have read and fully understand the above consent to operation, that the explanations therein referred to were made, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken in my presence and before I signed.

Signature of patient or guardian _____

Relationship to patient _____

Date _____

Witness _____