ETOBICOKE PERIODONTICS

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INFORMED CONSENT FOR INTRA-ORAL BIOPSY

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Specialist in Periodontics

PLEASE ASK IF YOU HAVE ANY QUESTIONS BEFORE SIGNING THIS DOCUMENT

A biopsy is a minor surgical procedure in which a sample tissue is removed and examined under a microscope to determine the nature of the condition.

Depending on the clinical findings, one of the following approaches may be taken:

- **Complete removal** of the lesion — when size and location allow and cancer is suspected
- **Partial removal** — when the lesion is large, not clearly cancerous, or complete removal may be unnecessarily complex at this stage

If the biopsy result is suspicious for disease, additional surgery may be required later to remove more tissue.

Local anesthesia will be used to numb the surgical area.
Other forms of anesthesia may be recommended depending on lesion location and patient comfort.

Risks & Possible Complications

Although rare, complications may include:

- Pain and swelling require several days of healing
- Bleeding that may require additional care
- Numbness, tingling, or altered sensation affecting:

If bone is removed:
– Healing may take longer
– Additional complications may occur

- Possibility of communication with the sinus (upper jaw biopsy cases)
- Recurrence of the lesion, even if completely removed

PATIENT RESPONSIBILITES

- Provide complete medical and dental history
- Return for follow-up appointments as recommended
- Inform Dr. Chang of any changes in condition or symptoms
- Follow all home care instructions to support healing
- Avoid harmful habits that may impair recovery

ACKNOWLEDGMENT & CONSENT

By checking each box, I confirm:

☐I understand the purpose of an intra-oral biopsy

☐ I understand that additional treatment may be necessary depending on results

☐I understand the risks and possible complications of surgery and anesthesia

☐ I understand no guarantee of results can be made

☐ I have provided a complete and truthful medical history

☐ I have had the opportunity to ask questions, and they were answered to my satisfaction

☐ I voluntarily consent to the biopsy procedure as recommended

DATE: _____

PATIENT NAME: _____

PATIENT SIGNATURE : _____

Provider Confirmation

I have explained the nature, purpose, risks, potential complications, alternatives, and the necessity of follow-up. I believe the patient understands the information given.

Provider Signature (Dr. Jae W. Chang): _____

Date: _____