CHIN AUGMENTATION CONSENT

1. I herby authorize Tom J. Pousti, M.D., F.A.C.S. to perform the following surgery known as mentoplasty or genioplasty:

_____

(patient's name)

2. I have met personally with the doctor, and the procedure has been explained to me by the above doctor. I understand the nature and consequences, including possible risks, of the procedure.

3. The following risks and side effects among others have been specifically made clear to me.

    a. There will be swelling for an intermediate period, but much of the swelling will normally disappear in a few days and the remainder may require several weeks or even months to completely disappear.
    b. There will be black and blue marks on and about the face, proc