DENT MD
EAR / NOSE / THROAT

Dr. Stephen Dent, M.D.

Balloon Sinuplasty

INFORMED CONSENT

1. I hereby request and authorize Dr. Dent, aided by any assistants he may require, to perform:

   Balloon Sinuplasty/MiniFESS and possible nasal turbinate reduction in-office

   In general terms, the nature and purpose of the operation (s) is:

   To surgically remove irreversibly diseased tissue from the paranasal sinuses and enlarge the natural openings of these sinuses in an attempt to improve chronic sinus infections/to surgically alter nasal turbinates in an attempt to improve nasal breathing or improve chronic facial pain and headaches.

2. Dr. Dent has fully explained in terms clear to me, the effect and nature of the operation(s) to be performed, the foreseeable risks involved, alternative methods of treatment including not operating and not treating at all, as well as what I can expect to experience if recovery is uneventful. Lastly, I acknowledge that I have been given an opportunity to ask questions and that these questions have been answered to my satisfaction.

3. I was told of other complications specific to my procedure including:
   1. Bleeding or infection.
   2. Failure to improve nasal airway and breathing.
   3. Formation of scar tissue with possible worsening of sinonasal function.
   4. Spinal fluid leakage from nose possibly requiring repair.
   5. Eye injury including double vision or visual loss.
   6. Loss of sense of smell.
   7. Dental or tooth pain and numbness.
   8. Permanent numbness of the operated area.
   9. Persistent intranasal or extranasal crusting.
   10. Possible perforation (hole) of the nasal septum that may require repair.
   11. Need for revision or staged procedures.

4. I also authorize the operating surgeon to perform any other procedures that he may deem necessary or desirable in attempting to achieve the desired result of the procedure(s) or the elimination of unhealthy or unforeseen conditions that he may encounter during the procedure(s).

5. I understand that Dr. Dent and his staff will make every effort to ensure a pleasing surgical outcome. I also realize that individual healing cannot be assured and that imperfections may ensue. Futhermore, I have been advised that minor revision procedures sometimes prove necessary and that I may incur additional financial responsibility for expenses not under the direct control of Dr. Dent.

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Patient/Legal Guardian: Date: