



George Min, MD, Board Cert
13114 120th Ave North East
Kirkland, WA 98034
P 425.821.6000
F 425.820.6288

SMOKING RISK CONSENT FORM

Patient: _____ Age: _____

I am not a smoker; I quit _____ months or _____ years ago.

I currently smoke _____ a day.

Patient: Signature: _____

Date: _____

I have been advised by Dr. George Min and their staff that I must not smoke or take nicotine substitutes for a minimum of six (6) weeks before my surgery. I have also been advised that being in the presence of secondhand smoke can compromise my surgery and its outcome.

It has been explained to me that the risks of surgery are much greater for smokers and even if I am off cigarettes for six (6) weeks before and after surgery I may still experience the effects of nicotine.

There is greater risk in smokers for bad scarring, hematoma formation, intraoperative bleeding, bleeding, poor or delayed healing, hair loss, sloughing of the skin (skin loss), infection, increased or prolonged bruising and hyperpigmentation.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO OPERATE, THAT THE RISKS HAVE BEEN FULLY EXPLAINED TO ME AND I WISH TO PROCEED WITH SURGERY.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____