

G. Paul Doxey, MD

Trusted, experienced personal ENT care

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G. PAUL DOXEY, MD

Board-Certified: American Board of Otolaryngology

Residency: Otolaryngology–Head & Neck Surgery, University of Utah Medical Center, Salt Lake City

MD: University of Utah College of Medicine, Salt Lake City

TRUSTED CARE FOR:

- Sinus/nasal problems
- Snoring & sleep apnea
- CT-guided sinus surgery
- Balloonplasty
- Deviated septum
- Nasal blockage/polyps
- Nasal fractures
- Nosebleeds
- Ear pain & infections
- Voice & swallowing disorders
- Care of the professional voice
- Perforated eardrum
- Head & neck surgery/cancer
- Thyroid & parathyroid surgery
- Allergies & testing
- Salivary gland infections & surgery
- Nose reshaping (rhinoplasty)
- Facial or nasal fracture repair
- Otoplasty (correction of overly prominent or poorly positioned ears)
- Neck masses
- Facial wound repair & reconstruction
- Surgical removal of facial moles & tumors

TRUSTED CONVENIENCE:

- Convenient location
- Friendly, courteous staff
- Most insurance accepted & filed
- Major credit cards welcome
- Convenient office hours
- Ample free parking

Surgical Consent

I authorize and request the performance upon

_____ (patient name)

of the following operation:

(surgical procedures)

to be performed by G. Paul Doxey, MD.

Dr. Doxey has explained to me my condition, the nature and purpose of the proposed procedures as well as any alternative treatment(s). My questions about the procedure and its risks have been answered in a satisfactory manner. I accept the risk of substantial and serious harm, if any, in hopes of obtaining desired benefits from the procedure. The significant possible risks are:

I also understand that the procedure involves the possibility of complications, which have been known to occur after the procedure(s) to which I am consenting, even when the utmost care, judgment and skill are used. No guarantees have been promised to me from this surgical procedure.

I recognize that during the procedure, unforeseen conditions may require additional or different procedures than those explained. I request that my physician perform those procedures as, in his professional judgment, are necessary and desirable. I request the administration of the anesthesia necessary and appropriate for the procedure.

Any tissues that may be removed from my body may be examined and then disposed of by hospital personnel.

I HAVE READ AND UNDERSTAND THIS DOCUMENT AND REQUEST THE PROPOSED CARE.

Signature

Relationship to Patient (if patient is a minor)

Date

Time

Witness