

**METRO DERMATOLOGY OF N.Y., P.C.**

41-61 KISSENA BOULEVARD, SUITE 5A • FLUSHING, NEW YORK 11355  
220 E. 161ST ST., BRONX, NEW YORK 10451  
40-12 80TH ST., ELMHURST, NEW YORK 11372

**METRO DERMATOLOGY OF N.J., P.C.**

500 GRAND AVENUESUITE 201, ENGLEWOOD, NEW JERSEY 07631

**EXTRACTION INFORMED CONSENT**

Date:

MR#:

Date of Birth

Name of Patient:

**Extraction** is a corrective technique that gently and safely removes blackheads, drains inflamed acne impactions and release trapped ingrown hairs when possible. \_\_\_\_\_  
Initial

**Side Effects:** Temporary or Permanent scarring, discoloration, mild tenderness, redness, swelling, sensitivity, flaking and small scabs. Superficial dark spots can occur when extracting old or deep lesions are extracted and are normal and mostly temporary (VARIES BY SKIN TYPE). Superficial blemishes may occur. The use of sun protection must be part of your daily regimen. \_\_\_\_\_  
Initial

**GUARANTEE:** We will attempt to remove larger lesions first and CANNOT guarantee any lesion will not "recur" at a later date. \_\_\_\_\_  
Initial

**INSTRUMENTATION:** All instruments are sterile and medical personnel use surgical gloves during the procedure. \_\_\_\_\_  
Initial

**INSTRUCTIONS:** Avoid the sun and use products exactly as directed to reduce formation of new lesions and help fadeexfoliate existing spots. Product overuse, scrubbing, picking and sunburn cause temporary dryness, irritation and POSSIBLE dark spots. AVOID prolonged exposure to direct sunlight, DO NOT pick and scratch, it will cause scarring. \_\_\_\_\_  
Initial

**ALLERGIC REACTIONS:** Allergy is rare but in the event that you have a reaction, discontinue the use of all medications and contact the office immediately. \_\_\_\_\_  
Initial

**To the Patient:** *You have the right to be informed about your condition and its treatment so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent for treatment.*

*I have read this form carefully and understand the nature of this treatment and its risks. I hereby give my informed consent to the practice to proceed with the treatment, extraction.*

\_\_\_\_\_  
Patient/Legal Guardian Signature Date

\_\_\_\_\_  
Provider Signature Date

\_\_\_\_\_  
Witness Signature Date