Ear Piercing Consent Form

Patient name ____ DOB ___________________

Initial below to indicate consent:

____ I understand that fees for ear piercing will not be filed against insurance. All payments for this service are due at the time of the visit.

____ I understand that my child's ears will be pierced with pre-sterilized, single-use Blomdahl cartridges of medical-grade plastic or titanium.

____ I understand that if my child is taking blood thinning medications, antibiotics, steroids, or antihistamines that ear piercing may carry a greater risk.

____ I attest that to the best of my knowledge, my child does not have high blood pressure, epilepsy, hemophilia or other bleeding disorders, a heart condition, or is pregnant.

____ I understand that ear piercing is a minor surgical procedure with similar risks to stitches and abscess drainage. Despite all precautions taken by Hometown Pediatrics and my proper following of aftercare instructions, the potential for infection still exists. There is also potential that one of the following complications may occur as a result of ear piercing: persistent redness, swelling, drainage, bleeding, embedded clasp, local infection, cellulitis, blood poisoning, keloids, cauliflower ear, pressure sore, or traumatic injury. I will contact Hometown Pediatrics if any of these occur or are suspected to have occurred.

____ I have read and understand the Aftercare Instructions and have received a copy for my reference. Aftercare of piercing is the responsibility of the patient or parent once they leave the office.

____ I have agreed to this ear-piercing procedure and am fully aware of the potential risks and complications. I have read and understand all the items listed above and agree to their terms. If the patient is a minor, then the undersigned certificates to Hometown Pediatrics that the undersigned is the parent or legal guardian of the minor patient named above.

Signature: ____