The Well MD: 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 acknowledge that if I am diabetic, immune-compromised, have high blood pressure, am pregnant, have epilepsy, have hemophilia or other bleeding disorders, or have a heart condition that ear piercing may carry a greater risk for me.

____ I understand that ear piercing is a minor surgical procedure with similar risks to stitches and abscess drainage. Despite all precautions taken by Olney 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 my pediatrician if any of these occur or are suspected to have occurred.

____ I have seen the proposed placement of the earrings, which were marked with a pen, and I agree to the placement on the earlobes. **(Do not initial here until you have seen the proposed placement)**

____ I agree to this ear piercing procedure, and am fully aware of the potential risks and complications.

____ I 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 read and understand all of the items listed above and agree to their terms. If the patient is a minor, then the undersigned certifies to The Well MD that he/she is the parent or legal guardian of the minor patient named above.

Signature: _____

Print name: _____

Relationship to patient: _____