SUBURBAN
Ear, Nose & Throat
Associates, Ltd.

Otolaryngology-
Head & Neck Surgery

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EAR PIERCING CONSENT FORM

By signing this consent I desire Suburban ENT Associates to pierce my or my child's ear/s. I have been given a copy of, read and understand the aftercare instructions. I realize the importance of proper care in permitting the ears to heal without infection. I understand that my ears will be pierced with pre-sterilized, single use ear piercing earrings that are packaged in individual sealed containers.

I understand that the fees for ear piercing will not be filed with my insurance. I understand that I am responsible for all payments for this service.

I understand that ear piercing is a minor surgical procedure. Despite proper precautions and proper following of the aftercare instructions, the small potential for complications exists. The complications that could occur are uncommon, but might involve:

Infection/cellulitis
Persistent redness
Swelling
Bleeding
Keloids
Dissatisfaction with earring location
Embedded post or ring in earlobe

At Suburban Ear, Nose and Throat Associates, Ltd., we go to great lengths to try to help you understand your plan of care. If at any time you have questions or concerns, please call us at 847-259-2530.

I have sufficient information to give this informed consent. I understand every effort will be made to provide a positive outcome, but there are no guarantees.

Printed name of person getting piercings: ___________________________

Signature of person, or if applies Parent/Guardian/POA: ___________________

If applies, Parent/Guardian/POA **printed** name:_______________________

If applies, Parent/Guardian/POA **relationship** to patient: ________________

Date: _____________________ Time: __________________

Witness: ___________________ Date: __________________