Consent for Wax Removal Procedure

Patient Name:

Date:

I hereby acknowledge that this procedure has been explained to me including possible side effects and risks associated with the procedure, which may include:

- Nausea
- Vomiting
- Dizziness
- Trauma of the ear canal
- Rupture of the ear drum
- Infection
- Failure to remove wax

I understand the risks involved and give my consent to having this procedure performed on myself.

Signed

Patient Name:

Date:

Signed

Witness Name:

Date: