



AFFILIATED TROY DERMATOLOGISTS

Traci Kimbrough, MD/Snehal Desai, MD
4600 Investment Drive Suite 150/260
Troy, MI 48098
P: 248-267-5020
F: 248-267-5021

EAR PIERCING CONSENT FORM

By signing this consent, I desire Affiliated Troy Dermatologist to pierce my or my child's ear/s. I have been given a copy of, read and understand the after-care 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 after-care 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 Affiliated Troy Dermatologist, 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 248 267 5020.

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 getting piercings, 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: _____

