Conder Medical & Dental Centre

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 (please print): .....
Date: .....

Signed:

Witness Name (please print): .....
Date: .....

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