PHYSICIAN ACKNOWLEDGEMENT FORM

TO BE FILLED OUT BY CLIENT

Client's Name: _____

Street Address _____

City _State _____ Zip Code _____

Client's Telephone Number: _____ Client's Date of Birth _____

Piercing To Be Performed _____

Condition That May Affect Healing of Piercing _____

I have read all aftercare instructions associated with this piercing and have had the opportunity to ask all questions associated with this procedure. I understand that infection is always a risk associated with piercing and the above listed health condition may further increase my chance of infection or complications during the healing process. Should any complications arise, I agree to seek medical attention.

Client's Signature _____ Date_

TO BE FILLED OUT BY PHYSICIAN

Physician's Name _____

Street Address _____

City _State _____ Zip Code _____

Physician's Telephone Number _____

I, the physician of the above patient, understand that the patient intends to have a body piercing performed at _____. As the patient's physician I am aware of the above listed health condition and am willing to treat the patient should any complications arise from the aforementioned condition.

My willingness to treat the patient should a problem arise, is in no way an endorsement of the practice of body piercing.

Physician's Signature _____ Date_