

Physician Acknowledgement Form

To Be Filled Out by Client

Client's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

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

Piercing to be Performed: _____

Condition that may affect the healing of piercing: _____

I have read the 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: _____

Physician's Telephone Number: _____

I, the physician of the above patient, understand that the patient intends to have a body piercing performed at Gamma Piercing. 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 conditioned.

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

Physician's Signature: _____ Date: _____