LONGHORN HEARING PLLC

## CERUMEN REMOVAL WAIVER

☐ By checking this box and signing below, I authorize the semi-invasive procedure of otoscopic examination of my ears and, if needed, cerumen (earwax) removal and impression taking of my ears. I understand there is a very slight possibility of discomfort and slight abrasion of my ear canals from these procedures.

Signature of Patient or Guarantor: _____

Printed Name: _____

Date: _____

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