

## **INFORMED CONSENT FOR PUNCTAL OCCLUSION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

A.M.

Date: \_\_\_\_\_ Time: \_\_\_\_\_

P.M.

1. I hereby authorize Dr. \_\_\_\_\_, to perform the following punctal occlusion procedure: TEMPORARY/PERMANENT on my RIGHT (upper/lower) LEFT (upper/lower). I further request and authorize him to do whatever he/she deems advisable.
2. The nature and the purpose of the procedure, possible alternate methods of treatment, the risks involved, and the possibility of complications, have been explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.
3. I consent to the taking of any photographs in the course of this procedure for the purpose of advancing medical education.

### **IMPORTANT:**

**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT, THE EXPLANATIONS THEREIN REFERRED TO WERE MADE AND THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED.**

\_\_\_\_\_  
Signature of Patient

Witness: \_\_\_\_\_