

Cerumen Management

Patient Name _____ Date _____

DOB _____ PCP _____

1. Have you used any ear wax softening agents? _____
2. Do you have a history of middle ear problem such as ruptured ear drums, ear infections or surgeries etc? _____
3. Are you diabetic? _____
4. Do you have ringing or buzzing in either ear? _____
5. Are you taking Coumadin or any other blood thinning medications? _____
6. Have you had cerumen removed before? _____

I am aware that Cerumen management is a non covered service and am aware that I will be responsible for full payment of this service

Patient Signature _____ Date _____

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