Patient Consent Form

Date: _____

I, **[Patient's Full Name]**, hereby give my consent for an examination of my ear, nose, and throat by Dr. **[Doctor's Full Name]** of **[Clinic/Hospital Name]**.

I understand that the purpose of the examination is to assess my condition and determine an appropriate treatment plan.

I have been informed about the nature of the examination and the possible risks involved. I acknowledge that I have had the opportunity to ask questions and all my queries have been answered to my satisfaction.

By signing this consent form, I confirm that I consent to the examination and the associated procedures that may be necessary for my care.

Patient Signature: _____

Witness Signature: _____

Doctor's Signature: _____