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Discussion and Refusal of Treatment

Patient's Name: _____

Recommended Treatment: _____

Risks of Not Having the Recommended Treatment

I understand that complications to my teeth, mouth, and/or general health may occur if I do not proceed with the recommended treatment. These complications may include:

_____
_____
_____

I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about.

Acknowledgement

I, _____, have received information about the proposed treatment. I have discussed my treatment with Dr. _____ and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, and the risks of the recommended treatment and my refusal of care.

I assume the risks and consequences of my refusal and release for myself, my heirs, executors, administrators or personal representatives, those dentists who have been consulted in my case from any liability for ill effects which may result from my refusal to consent to the performance of the proposed treatment.

I acknowledge that I have read this document in its entirety, that I fully understand it, and that all blank spaces have been completed or crossed off prior to my signing.

I do NOT wish to proceed with the recommended treatment.

Signed:_____ Date:_____
Parent or Guardian

Signed:_____ Date:_____
Treating Dentist