REFUSAL OF RECOMMENDED TREATMENT

Patient name: _____ Date of birth: _____

You have both the right and the obligation to make decisions regarding your health care. Your dentist can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision-making process. This form will acknowledge your refusal of treatment recommended by your dentist.

Dr. _____ has recommended the following treatment to me:

_____

This treatment has been recommended to me for the purpose of:

_____

The possible benefits of proceeding with the recommended treatment include:

_____

The possible risks and complications of refusing the recommended treatment could include but are not limited to:

_____

These potential risks and complications could result in additional medical or dental treatment or procedures, tooth loss, hospitalization, blood transfusions, or very rarely permanent disability or death.

I have chosen to refuse this treatment after considering both the recommended and alternative forms of diagnosis and/or treatment for my condition. Each of these alternative forms of diagnosis or treatment has its own potential benefits, risks and complications.

I certify that I have read or had read to me the contents of this form. I understand the possible advantages from proceeding with the recommended treatment and the possible risks and consequences of refusing the recommended treatment. I have decided to refuse the treatment recommended by my dentist. I hereby release Dr. _____ and his or her employees, partners, agents, or corporation from any liability for any and all injuries and damages I may sustain as a result of my refusing recommended dental treatment. I attest that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

PATIENT'S SIGNATURE: _____

DATE: _____ TIME: _____ WITNESS: _____