

INFORMED REFUSAL OF TREATMENT

Patient's Name

Date of Birth

This form and your discussion with your doctor are intended to help you make informed decisions about your oral health care. Your doctor will be happy to answer any questions you may have, and provide you with additional information before you decide whether to sign this document.

Dr. _____ has recommended the following: _____, and _____ has explained the potential benefits and alternatives.

Risks of Not Having the Recommended Treatment

I understand that complications with my teeth, mouth and/or general health may occur if I do not proceed with the recommended treatment. My condition may also worsen as a result and/or require additional therapy, hospitalization or, in rare circumstances, my condition may be life threatening if left untreated. Additional complications include, but are not limited to: _____

Acknowledgement

I, _____, acknowledge that my condition has been evaluated and explained to me by my doctor, who has recommended treatment, as stated above. The doctor has explained to me the nature of the recommended treatment, and the potential risks and alternatives. The risks of my refusal of care have also been explained to me, and I fully understand them. I have had an opportunity to ask questions and have had them answered. With this understanding, I refuse to consent to this treatment. I realize I may reconsider my decision at any time by notifying my doctor.

By signing this document, I acknowledge and accept the possible risks and complications of refusing the recommended treatment.

Signature of Patient or Legal Representative/Relationship

Date

Signature of Doctor

Date

Signature of Witness

Date