

Refusal of Recommended Treatment

Patient Name _____ Date _____

You have the right and obligation to make decisions regarding your healthcare. Your dentist can provide you with necessary information and advice, but as a member of the healthcare 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 of 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/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 Signature

Date

Printed Name (if signed on behalf of patient)

Relationship

Dentist Signature

Date

Witness Signature

Date

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