REFUSAL TO CONSENT TO DENTAL TREATMENT

Patient's Initials

_____ I understand and refuse the following treatment, medication, examination, or procedure recommended by my dentist:

_____

_____

_____

_____.

_____ I am aware that this refusal is against the advice of my dentist.

_____ I am aware of the risks associated with this action, including the fact that my condition may worsen.

_____ I hereby release Dr. _____and his/her dental staff from all responsibility for any ill effects that may result from my refusal of treatment, medication, examination or procedure.

_____ My dentist has answered all my questions.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

_____ _____

Patient or Legal Representative Signature/ Date/Time *Relationship to Patient*

_____ _____

Print Patient or Legal Representative Name *Witness Signature/Date/Time*

I certify that I have explained the nature, purpose, anticipated benefits, material risks, possible complications, and alternatives to the proposed procedure/treatment and the risks and consequences of not proceeding, to the patient or the patient's legal representative. I have answered all questions fully, and I believe the patient/legal representative *(circle one)* fully understands what I have explained.

_____

Dentist/Surgeon Signature/Date/Time

_____ Copy given to patient
Initials

_____ Original placed in patient's chart
Initials

10/15

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and The Joint Commission requirements, if applicable, and legal requirements of your individual state(s).