Discussion and Refusal of Treatment

Patient's Name _____ Date of Birth _____
Last First Initial

I am being provided this information and refusal form so I may fully understand the treatment recommended for me and the consequences of my refusal. I want to be provided with enough information, in a way I can understand, to make a well-informed decision regarding my proposed treatment.

I understand that I may ASK ANY QUESTIONS I WISH regarding the recommended treatment.

Nature of the Recommended Treatment

It has been recommended that I have the following treatment: _____

_____

_____

This recommendation is based on visual examination(s), on any x-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. The treatment is necessary because of:

❒ Decay ❒ Broken Tooth/Teeth ❒ Infection ❒ Periodontal (gum) disease ❒ Pain

❒ Other _____

_____

The intended benefit of this treatment is: _____

_____

The prognosis, or chance of success, of this treatment is: _____

My treatment is estimated to take _____ visits to complete.

My treatment is estimated to cost $_____.

Alternative Treatments

The treatment recommended for me was chosen because it is believed to best suit my needs. I understand that alternative ways to treat my dental condition include: _____

_____

❒ No other reasonable treatment option exists for my condition.

_____ I have had an opportunity to ask questions about these alternatives and any other treatments I have
Patient's Initials heard or thought about, including _____.

Risks of the Recommended Treatment

Patient: _____

I understand that no dental treatment is completely risk free and that my dentist would take reasonable steps to limit any complications of my treatment.. I understand that some after-treatment effects and complications tend to occur with regularity. These include:

_____

_____

_____

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 include:

_____

_____

_____

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

Patient's Initials

Acknowledgment

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 do NOT wish to proceed with the recommended treatment.

Signed: _____ Date: _____
Patient or Guardian

Signed: _____ Date: _____
Treating Dentist

Signed: _____ Date: _____
Witness

This sample form is for illustrative purposes only. As each practice presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar forms in your practice.