

INFORMED REFUSAL SAMPLE FORM

Dr. _____ has informed me of my dental condition and recommended the following treatment plan.

The benefits of this treatment included, but are not limited to:

The possible consequences and/or complications of not proceeding with the treatment include but are not limited to:

I understand complications to my oral and general health may occur if I do not proceed with the treatment recommended.

I have read or had this document read to me in its entirety. I have had the chance to ask questions and have them answered to my satisfaction so that I feel I understand the information as it was presented. I understand the potential risks, complications and side effects. I have elected **not** to proceed with the recommended dental treatment after having considered both the known and unknown risks, complications, side effects and alternative treatment methods.

I hereby assume all responsibility for my oral and general health condition and release Dr. _____ and his employees from any and all liabilities which may result from my refusal to consent to the treatment.

Patient (or Legal Guardian) Signature: _____

Patient Printed Name: _____

Date: _____

Doctor's Signature: _____

Date: _____

Witness Signature: _____

Date: _____