INFORMED REFUSAL

Consent is a process. It is the communication between a patient and a dentist in which each party asks questions and exchanges information, resulting in both the patient and the dentist agreeing to specific dental, surgical, pharmaceutical, or diagnostic interventions.

It is the obligation of the dentist to provide you, the patient, with the information and advice needed to make your dental care choices. Ultimately, however, the decision for your dental and health care rests with you. This form will serve to acknowledge your refusal of the interventions and treatments prescribed by your dentist.

I, _____ acknowledge that:

1. Dr. _____ has recommended _____

   _____

2. The recommendation has been made to me for the purpose of

   _____

3. I have decided to refuse the recommendation. _____ (initials)

4. My decision has been made after considering both the prescribed treatment as well as any other alternative forms of treatment or diagnostic study for my condition. I fully understand that each of the alternative forms of treatment/diagnostic study has its own potential benefits, risks, and complications. _____ (initials)

5. I completely understand that there are possible risks, complications, and side effects involved in refusing dental and/or medical treatment. I also understand that it is impossible to list every risk, complication, and/or side effect involved in my refusal, however I have been educated to some of them. They could include, but not be limited to, the following:

   _____

   _____

   Although these risks, complications and side effects may be rare, they do sometimes occur and cannot be predicted or prevented by the dental care provider. I acknowledge that no guarantee has been made to me about the results of refusing the prescribed treatment/diagnostic study.

   _____ (initials)

6. I am aware that the potential risks and complications involved in refusing dental and/or medical treatment can result in additional dental or surgical treatment, prolonged hospitalization or even permanent disability, severe injuries or death. _____ (initials)

7. I certify that I have read (or had read to me) the entire contents of this form. I acknowledge that the possible risks and consequences created by my refusal to permit the recommended treatment have been fully explained to me. I understand the possible benefits for allowing the recommended treatment and the possible risks and consequences to myself because of my refusal for same.

_____

Patient or Legal Guardian Signature Relationship to Patient

_____

Witness

_____

Date