Sample Form: Discussion and Refusal of Treatment

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

I am being provided with this information and refusal form so that I may better understand the treatment recommended for me and the consequences of my refusal. I wish to be provided with enough information, in a way I can understand, in order 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 likelihood 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 heard or thought about, including:_____.
Patient's Initials

continued…

Risks of the Recommended Treatment

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 I may be given a topical anesthetic and/or local anesthetic injection. Although rare, it is possible that patients may have an allergic reaction to these medications. Adverse reactions to anesthetic medications are possible, such as lightheadedness, dizziness or drowsiness. Please contact Dr. _____ if numbness remains more than a few hours or if you develop a rash. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from the anesthetic injection. I also understand that temporary or permanent injury to nerves and/or blood vessels from the injection may occur. Nerve disturbances may include pain or numbness, and/or unusual sensations such as itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.

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.

(The following release is optional.)

I personally assume the risks and consequences of my treatment refusal, and release for myself, my heirs, executors, administrators, or personal representatives those dentists who have been consulted in my case from any and all liability for ill effects which may result from my refusal to consent to the performance of the proposed treatment.

I acknowledge that I have read this document in its entirety, that I fully understand it and that all blank spaces have been either completed or crossed off prior to my signing.

I do NOT wish to proceed with the recommended treatment.

Signed:_____ Date:_____
Patient or Guardian

Signed:_____ Date:_____
Treating Dentist

Signed:_____ Date:_____
Witness