AS4U0716 -Refusal of Dental Treatment

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A Smile 4U - Refusal of Dental Treatment
Risks of Not Having the Recommended Treatment:

I, name of parent or legal guardian if child under 18), hereby understand that complications to my teeth, mouth, and/or general health may occur if I do not proceed with the recommended treatment. Recommended Treatment:

I have received enough information to make a well-informed decision regarding refusal of dental treatment. I have had an opportunity to ask questions about these risks for not agreeing to the recommended treatment.

Acknowledgement:

I, (name of parent or legal guardian if child under 18), 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 if any, and the risks of the recommended treatment, and my refusal of care.

I personally assume the risks and consequences of my 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 completed prior to my signing.

I do not wish to proceed with the recommended treatment:

Patient/Parent/Legal Guardian Signature: _____
(if patient is a minor under the age of 18)