Informed refusal of necessary x-rays

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You have the right and obligation to make decisions regarding your health care. Your dentist can provide you with the necessary information and advice, but you must participate in the decision-making process. This form will acknowledge your refusal of treatment recommended by your dentist.

The Doctor has advised me to have necessary x-rays for the accurate diagnosis and treatment of possible dental conditions in my mouth. The doctor and/or dental team have explained the importance of these diagnostic tools and have discussed with me the potential risks of not having necessary x-rays on my oral health. These potential risks and complications could result in additional medical or dental treatment or procedures, tooth loss, hospitalization, blood transfusions, or very rarely disability or death.

I certify that I have read the contents of this form. I understand the possible advantages of proceeding with the recommended treatment and the possible risks and consequences of refusing the recommended treatment.

Having been informed, I elect not to have the necessary x-rays at this time. I hereby release the doctor and any team members from any liability for all injuries or damages I may sustain because of my refusal. I attest that I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.

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