# REFUSAL OF TREATMENT (GENERAL)

Print Name: _____

I am being provided this information and refusal form so I may fully 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, 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 dentist's knowledge of my medical and dental history. The treatment is necessary because of:

❑ Broken tooth/teeth ❑ Infection ❑ Periodontal (Gum) Disease ❑ Pain ❑ Decay

❑ Other (Explain):

The intended benefit of this treatment is:

The prognosis, or chance of success, of this treatment is: ❑ Good ❑ Fair ❑ Poor

The estimated cost of my treatment has been provided.

**Alternate Treatments**

The treatment recommended for me was chosen because it is believed to best suit my needs. No other reasonable treatment option exists for my condition.

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I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about.

**Refusal of Treatment**

I have discussed my treatment with my dentist and I have chosen to refuse the proposed treatment at this time.

Signed: _____ Date: _____

Parent or Guardian Signed: _____ Date: _____

Treating Dentist Signed: _____ Date: _____