REFUSAL OF TREATMENT (X-RAYS)

Print Name: _____

I am being provided this information and refusal form so I may fully understand the procedure recommended for me and the consequences of my refusal. I wish to be provided with enough information to make a well-informed decision regarding the proposed procedure.

It has been recommended that I have routine diagnostic radiographs based on the Canadian Dental Association's guidelines (a full mouth series every 3-5 years and bitewings every 1-2 years). I understand that the radiographs are necessary for my dentist to diagnose and treat possible decay (cavities), infection, fractured teeth, bone loss due to gum disease, and tumors. Without periodic radiographs, my dentist cannot identify and disclose to me potential problems, which could lead to serious jaw infections, tooth loss, and bone destruction leading to potential jaw fractures. No other reasonable option to dental radiographs exists at this time. I am informed that the dose of radiation is minimal from such dental radiographs, and that all necessary precautions will be taken to ensure exposure is reduced as much as possible (lead apron, collar and digital imaging).

I have had an opportunity to ask questions about dental radiographs, risks of x-ray exposure, and risks associated with not taking them. I have received the above information about the proposed radiographs. I have discussed my treatment with my dentist and have been given the opportunity to ask questions and have them fully answered. My dentist has informed me of the need for dental radiographs, risks associated with not taking radiographs, and my refusal to take radiographs. I also understand that my dentist may refuse to treat me if I refuse necessary diagnostic radiographs.

Signed: _____ Date: _____

Parent or Guardian Signed: _____ Date: _____

Treating Dentist Signed: _____ Date: _____