



Cancellation of Service

Patient Name: _____
Last First MI Nickname

Date of Birth: ____/____/____

This is to acknowledge the cancellation of all services provided by Mobile Dentistry of Arizona.

Acknowledgment

I have been made aware that complications to my teeth, mouth, and/or general health may occur if I do not proceed with the services. I have had an opportunity to ask questions about these risks and any other risks that I have heard or thought about. I have discussed the recommended treatment with the dentist or staff and my questions have been fully answered. I understand the nature of the recommended treatment, alternative treatment options, the risks of the recommended treatment, and the risks of my refusal of care.

I personally assume the risks and consequences of my cancellation of service, 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 and that I fully understand it. If signing as a guardian or Power Of Attorney, I am affirming my legal authority to make such decisions on behalf of the patient and I accept full responsibility for my decision.

I Do **NOT** wish to continue with services provided by Mobile Dentistry of Arizona and I have made arrangements with a new dental provider listed below.

New Dental Provider: _____

Phone: _____ Fax: _____ Email _____

➡ **X** _____
MUST BE SIGNED HERE Patient / Responsible Party / Power of Attorney Date

➡ **X** _____
MUST BE SIGNED HERE Witness Date