Mobile Dentistry of Arizona

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Refusal of Treatment

Patient Name:_____
Last First MI Nickname

Date of Birth:____/____/_____

Discussion and Refusal of Treatment:
Treatment Recommended:

_____

This recommendation is based upon visual examination(s), on any x-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history.
The treatment is necessary because of:

☐ Decay Broken Tooth/Teeth ☐ Infection Periodontal (Gum) Disease

☐ Pain ☐ Other _____

Notes _____

_____

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 recommended treatment. 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 refusal of treatment, 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 proceed with the recommended treatment.

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

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