Roseville Smiles Family Dentistry
Informed Refusal

Patient Name: _____

Diagnosis: _____

Dr._____ has advised me that the following treatment **(describe the treatment)**

_____

_____

_____

test, or evaluation needs to be performed on **(name of patient)**
I have discussed with Dr._____ the risks, benefits, and alternatives of this treatment, test or evaluation. The consequences of no treatment, test or evaluation could lead to, but are not limited to: _____. I have had the opportunity to ask any questions I have regarding the treatment, test or evaluation. All of my questions have been answered to my satisfaction, and I hereby confirm that I do **not** want the treatment, test or evaluation.

I also understand that if refusing this treatment, test or evaluation could lead to a departure in the standard of care, Dr. _____ may dismiss me from the practice.

_____

Patient's or Legal Guardian's/Representative's Signature Date

_____

Witness' Signature Relationship Date

I have explained the nature, purpose, benefits, and alternatives of the proposed treatment, test or evaluation, as well as the risks and consequences of proceeding or not proceeding with the treatment, test or evaluation. I have answered all of the patient's questions, and I believe the patient/guardian/representative fully understands my answers and explanations.

_____

Dentist's Signature Date

Place a Copy in the Patient's Chart