



# Refusal of Dental Treatment Template

This sample form is for illustrative purposes only. As each practice presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar forms in your practice.

## Refusal of Dental Treatment

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I am being provided this information and refusal form so I may fully understand the treatment recommended for me, make a well-informed decision regarding my proposed treatment, and understand the consequences of my refusal.

I understand that I may ask any questions I wish regarding the recommended treatment.

### Nature of Recommended Treatment

It has been recommended that I have the following treatment:

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This recommendation is based on visual examination(s), any x-rays, models, photos, and other diagnostic tests, and 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: \_\_\_\_\_

The intended benefit of this treatment is: \_\_\_\_\_

\_\_\_\_\_

The prognosis, or chance of success, of this treatment is: \_\_\_\_\_

My treatment is estimated to take \_\_\_\_\_ visits to complete.

My treatment is estimated to cost \$\_\_\_\_\_.

### Alternative Treatments

The treatment recommended for me was chosen because it is believed to best suit my needs. I understand that alternative ways to treat my dental condition include:

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No other reasonable treatment option exists for my condition.

\_\_\_\_\_ I have had an opportunity to ask questions about these alternatives and any other  
Patient Initials treatments I have heard or thought about, including \_\_\_\_\_.

**Risks of Recommended Treatment**

I understand that no dental treatment is completely risk free and that my dentist would take reasonable steps to limit any complications of my treatment. I understand that some after-treatment effects and complications tend to occur with regularity. These include:

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**Risks of Not Having Recommended Treatment**

I understand that complications to my teeth, mouth, and/or general health may occur if I do NOT proceed with the recommended treatment. These complications include:

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\_\_\_\_\_ I have had an opportunity to ask questions about these risks and any other risks  
Patient Initials I have heard or thought about.

**Acknowledgment**

I, \_\_\_\_\_, have received information about the proposed treatment. I have discussed my treatment with Dr. \_\_\_\_\_ and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, and the risks of the recommended treatment and my refusal of care.

**I do NOT wish to proceed with the recommended treatment.**

\_\_\_\_\_  
Signature (Patient/Parent/Guardian)

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Relationship (if patient is a minor)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date/Time