PREMIERE DENTAL

Informed Refusal Form

Patient Name: _____ Date: _____

I am provided with this refusal form and information so I may understand the recommended treatment and the consequences of refusing treatment. I have had an opportunity to discuss and ask questions concerning the recommendations and alternative treatment recommendations.

The risks and complications to my oral and overall health have been explained to me if I do not proceed with the recommended treatment.

Complications include:
_____

I have received the proposed treatment recommendations with the risks and complication information. I understand the recommendations and risks related to refusal of care.

Signed Patient_____ Signed Dentist_____ Date _____