Refusal of Consent for Recommended Treatment or Procedure

I have been advised by Dr._____ that he/she recommends that I undergo a treatment/procedure known as _____
_____
_____

My dentist has fully explained to me the purpose of the operation/procedure and has also informed me of expected benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise, and alternatives to the proposed treatment, including no treatment. The dentist has also explained to me the consequences of my refusal of such treatment; including but not limited to serious permanent injury and even death.

I nonetheless refuse to consent to the proposed treatment. I hereby release Dr. _____, his associates and assistants from any liability for adverse effects which may result from failure to perform the proposed treatment.

I have been given an opportunity to ask questions, and all of my questions have answered fully and satisfactorily.

I confirm that I have read and understand the above. All blank spaces were completed prior to my signing. I have crossed out any paragraphs or words that do not pertain to me.

_____	_____	_____
Patient/Relative/Guardian*	Print Name	Date/Time

_____
Relationship to Patient

_____	_____	_____
Interpreter (if required)	Print Name	Date/Time

_____	_____	_____
Witness	Print Name	Date/Time

*The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment and attendant risks) the proposed operation(s)/procedure(s). I have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

_____	_____	_____
Dentist's Signature	Print Name	Date/Time

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD