

Date: _____

Patient: _____

Date of Birth: _____

I have been informed by Dr. _____ of my condition and the recommended treatment consisting of:

Or the referral to:

I have also been offered alternative options which include:

- I considered the proposed treatment, benefits, risks, and alternative options.
- All of my questions have been answered to my satisfaction; I have voluntarily chosen to refuse treatment or referral.
- I understand that my decision goes against my doctor's advice. My condition may worsen, require more therapy, tooth/teeth loss, or other conditions and I accept all responsibility for my decision.

Patient/Legal Guardian Name: _____
Patient/Legal Guardian Signature: _____
Interpreter (if needed): _____
Witness: _____