Refusal of Dental/Radiographic Examination

James D. Thomas, DDS Kala Foster, DDS
James D. Thomas, DDS, PC ❖ 6240 Hill Street, Cass City, MI 48726 ❖ Phone: (989) 872-3870

Patient's Name _____ Date of Birth _____
Last First Initial

I am being provided this information and refusal form so I may fully understand the diagnostic recommended for me and the consequences of my refusal. I want to be provided with enough information, in a way I can understand, to make a well-informed decision regarding my proposed treatment.

I understand that I may ASK ANY QUESTIONS I WISH regarding the recommended examination.

Nature of the Recommended Diagnostic Examination

It has been recommended that I have the following:

_____
_____

This recommendation is based on the Standards of Care for a dental practice and the laws of the State of Michigan, as well as on my doctor's knowledge of my medical and dental history. The examination is necessary because of:

☐ Previous treatment needs ☐ Findings during this or previous visits ☐ Length of since last examination of this nature ☐ Periodontal (gum) disease ☐ Pain ☐ Periodic cancer screening
☐ Other _____
_____

The intended benefit of this examination is:

_____

My examination is estimated to cost $_____.

Alternatives

The examination recommended for me was chosen because it is believed to best suit my needs. I understand that Alternatives to the examination include: _____

_____

☐ No other reasonable options exist for my condition.

_____ I have had an opportunity to ask questions about these alternatives and any other optiopns I
Patient's Initials have heard or thought about, including _____.

Risks of the Recommended Examination

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

_____
_____
_____

Patient _____

Risks of Not Having the Recommended Examination

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

_____
_____
_____

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

Acknowledgment

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

I <u>DO NOT</u> wish to proceed with the recommended examination.

Signed: _____ Date: _____
Patient or Guardian

Signed: _____ Date: _____
Treating Dentist

Signed: _____ Date: _____
Witness