NORTH BETHESDA PERIODONTAL GROUP

KHALID CHOUDHARY, DDS, MS ◊ JOAN HOWANITZ, DDS MS

DIPLOMATES AMERICAN BOARD OF PERIODONTOLOGY

# Refusal of Dental Treatment Form

Patient Name: ____________________________________________________ Date: _____________________

**Risks of Not Having the 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:

______________________________________________________________________________________________________

_____________________________________________________________________________________________________

______________________________________________________________________________________________________.

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

**Acknowledgement:**

I, _________________________________________________, have received information about the proposed treatment. I have discussed my treatment with Dr. Khalid Choudhary and Dr. Joan Howanitz 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 personally assume the risks and consequences of my refusal, and release for myself, my heirs, executors, administrators, or personal representatives those dentists who have been consulted in my case from any and all liability for ill effects which may result from my refusal to consent to the performance of the proposed treatment.

I acknowledge that I have read this document in its entirety, that I fully understand it and that all blank spaces have been completed or crossed off prior to my signing.

I do NOT wish to proceed with the recommended treatment.

**PLEASE ASK THE DOCTOR OR ANY OF THE STAFF IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT.**

Patient (Or Legal Guardian) Signature: _____________________________________________________ Date: ______________________

Dentist Signature: _______________________________________________________________________ Date: ______________________

Witness Signature: _______________________________________________________________________ Date: ______________________