



North Bethesda Periodontal Group

X-Ray and Records Refusal Form

Patient Name

Address

City, State, Zip

"I, _____, have been advised to have radiographs (x-rays) taken as part of a complete and thorough exam, in order to assist in thoroughly diagnosing oral or dental diseases that may be present (some of which can be detected only with radiographs):"

"I understand that by not having the recommended radiographs, conditions may arise at any time in the future that could have been prevented, detected earlier, and treated more successfully and less expensive if the radiographs were taken. These conditions can include tooth decay, gum disease, infections, cysts, and tumors. Not diagnosing them early could result in more pain and discomfort, more expensive treatment, losing teeth that might otherwise be saved, and not detecting growths until they are very large."

"I am refusing to have these radiographs taken at this time. I therefore release *Dr. Khalid Choudhary or Dr. Joan Howanitz* from any and all liability resulting from diseases or pathology, now or in the future, that these radiographs might have revealed."

(Patient signature or Legal Guardian signature)

Date

Witness Signature

Date

Doctor Signature

Date

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