

PATIENT NUMBER

© 2001 Wisconsin Dental Association
(800) 243-4675

PATIENT'S NAME _____
Last First Date of Birth

After an examination, the dentist has explained that my dental condition is:

The dentist has recommended the following treatment:

The dentist has advised me of the risks and consequences of the treatment.

The dentist has advised me of the risks and consequences should I choose not to have this treatment done.

The dentist has advised me of alternative treatments.

The dentist has advised me of the risks, advantages, and disadvantages of these alternative treatments.

I understand the nature of the recommended treatment, alternate treatment options, and the risks of the recommended treatment and my refusal of care.

I have had the opportunity to ask questions and receive answers to and responsive explanations for all questions about my medical condition, contemplated and alternative treatment and procedures, and the risks and potential complications of the contemplated and alternative treatments and procedures, prior to signing this form.

I DO NOT wish to proceed with the recommended treatment.

Patient or Guardian's Signature Date

I have personally explained the above information to the patient or the patient's guardian.

Dentist's Signature Date

Witness's Signature Date

INFORMED REFUSAL