

EXCLUSIVE ORAL SURGERY, LLC

'A Dental Destination Location'

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INFORMED REFUSAL OF TREATMENT

Patient's Name:

Date:

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

I have also been offered alternative treatments that include: _____

After considering the treatment possibilities offered, and having the benefits and risks of each explained to my satisfaction, I have voluntarily chosen to: _____

I understand that my decision is contrary to the treatment recommended by my doctor and that my condition may significantly worsen as a result and/or require additional therapy and/or hospitalization, and in rare circumstances may be life threatening.

I realize that I may reconsider my decision at any time by notifying my doctor.

Patient's (or Legal Guardian's) Signature

Date

Doctor's Signature

Date

Witness' Signature

Date