

TREATMENT REFUSAL FORMS

These forms are intended to be used when a patient refuses the treatment. These forms help confirm that the patient is informed and aware of the risks involved with not proceeding with recommended treatment.

Form A

(Doctor Name), DDS
(DOCTOR'S ADDRESS)

**DISCUSSION AND REFUSAL OF TREATMENT
Diagnostic Radiographs (X-Rays)**

Patient's Name _____

I am being provided this information and refusal form so I may fully understand the procedure recommended for me and the consequences of my refusal. I wish to be provided with enough information to make a well-informed decision regarding the proposed procedure.

It has been recommended that I have routine diagnostic radiographs based on the American Dental Associations guidelines (a full mouth series every 3-5 years and bitewings every 1-2 years). I understand that the radiographs are necessary for my dentist to diagnose and treat possible decay (cavities), infection, fractured teeth, bone loss due to gum disease, and tumors. Without periodic radiographs, my dentist cannot identify and disclose to me potential problems, which could lead to serious jaw infections, tooth loss, and bone destruction leading to potential jaw fractures.

No other reasonable option to dental radiographs exists at this time. I am informed that the dose of radiation is minimal from such dental radiographs, and that all necessary precautions will be taken to ensure exposure is minimal (lead apron, collar and digital imaging).

_____ I have had an opportunity to ask questions about dental radiographs, risks of x-ray exposure, and risks associated with not taking them.

I have received the above information about the proposed radiographs. I have discussed my treatment with **Dr.** _____ and have been given the opportunity to ask questions and have them fully answered. **Dr.** _____ has informed me of the need for dental radiographs, risks associated with not taking radiographs, and my refusal to take radiographs. I also understand that **Dr.** _____ will refuse to treat me if I refuse necessary diagnostic radiographs.

Signed: _____ Date: _____
Patient or Guardian

Signed: _____ Date: _____
Treating Dentist

Signed: _____ Date: _____
Witness

Form B

YOUR OFFICE HEADER

Discussion and Refusal of Treatment

Patient's Name: _____

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. _____ 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.

Signed: _____ Date: _____
Patient or Guardian

Signed: _____ Date: _____
Treating Dentist

Signed: _____ Date: _____
Witness

YOUR OFFICE HEADER

Discussion and Refusal of Treatment

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

I am being provided this information and refusal form so I may fully understand the treatment recommended for me and the consequences of my refusal. I wish 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 treatment.

Nature of the Recommended Treatment

It has been recommended that I have the following treatment: _____

This recommendation is based on visual examination(s), on any x-rays, models, photos and other diagnostic tests taken, and on my doctor's knowledge of my medical and dental history. The treatment is necessary because of:

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Decay | <input type="checkbox"/> Broken Tooth/Teeth |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Periodontal (Gum) Disease |
| <input type="checkbox"/> Pain | <input type="checkbox"/> Other _____ |

The intended benefit of this treatment is: _____

The prognosis, or chance of success, of this treatment is: _____

My treatment is estimated to take _____ visits to complete.

My treatment is estimated to cost \$ _____.

Alternate Treatments

The treatment recommended for me was chosen because it is believed to best suit my needs.

I understand that alternative ways to treat my dental condition include _____

- No other reasonable treatment option exists for my condition.

_____ I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including _____

Risks of the Recommended Treatment

I understand that no dental treatment is completely risk free and that my dentist will take reasonable steps to limit any complications of my treatment. I understand that some after-treatment effects and complications tend to occur with regularity. These include _____

LASER ASSISTED NEW ATTACHMENT PROCEDURE
INFORMED CONSENT

I consent to _____, DDS performing LANAP (Laser Assisted New Attachment Procedure) therapy on me.

I. BENEFITS OF LANAP

LANAP therapy is designed to eliminate or substantially reduce periodontally diseased gums and/or pockets to help control or prevent future periodontal disease progression.

LANAP reduces periodontal gum pocket depth by facilitating:

- A) Improved visualization of the laser detached gum pocket soft tissue linings to aid scaling and root planing for removal of tartar (calculus).
- B) Re-attachment of the laser treated gum tissues to the roots by promoting growth of new bone and/or root surfaces. LANAP treatments are generally less painful than flap surgical procedures. LANAP peer reviewed research proves predictable re-attachment of gum tissue and bone growth to promote long term periodontal health and to preserve teeth.

II. ALTERNATIVE THERAPIES

Dr. _____ has explained to me alternatives, benefits, and potential complications of treatments for my periodontal disease as follows:

A) Non-surgical root planing

After local anesthetic injections of my gums, root surfaces are scaled and deep cleaned (planed) to the bottom of any gum pockets by hand or ultrasonic instruments to remove bacterial plaque on teeth and root tartar (calculus) deposits.

B) Periodontal flap surgery

After local anesthesia injections, flap surgery involves surgically incising my gum tissues. After the gums are flapped and surgically lifted away from my teeth, underlying diseased gum tissue is curetted out, roots planed, diseased bone trimmed and/or grafted. Finally the flap of gum tissue is closed with sutures.

C) Complications

Non-surgical scaling and root planing alone may not eliminate or substantially reduce deep pockets. LANAP may be done for further periodontal pocket depth

reduction if root planing does not shrink deep gum pockets. Periodontal surgery treatment risks include post-operative bleeding, infection, swelling, sinusitis and in surgeries close to facial nerves on rare occasions numbness and/or pain of the lip, chin and gums.

III. LANAP COMPLICATIONS

LANAP post-surgical complications, if any, are usually milder, less severe and not as long lasting as conventional periodontal flap surgery complications.

IV. LANAP- NO GUARANTEE

LANAP, as with all periodontal procedures, may not be entirely successful in gum pocket reduction or new attachment. Success is not guaranteed. Nonetheless, other LANAP performing dentists report that almost 90% of LANAP treated patients required no LANAP re-treatment during the first 5 years after LANAP therapy.

V. NON-TREATMENT RISKS

Doing nothing can worsen my periodontal disease including increased gum pocket depth which predisposes to early (premature) teeth loss, infections, and abscesses. Lost teeth require replacement with costly implants, crowns, bridges, or partial/complete dentures.

VI. PATIENT COMPLIANCE

I agree to follow Dr. _____'s written and oral post-operative instructions including post-surgical oral hygiene and take medications given or prescribed. I also agree to schedule regular periodontal maintenance visits quarterly or as Dr. _____ may recommend to aid in maintaining my periodontal health.

Date _____ Patient or Guardian _____

Witness _____