INFORMED REFUSAL OF PERIODONTAL TREATMENT

Patient Name: ____________________________

I voluntarily decline to accept your recommendation of periodontal treatment. You have informed me that periodontal treatment is necessary for my dental health. You have explained that the risks involved in declining such treatment include, but are not limited to:

- A progressive deterioration of supporting gum tissue.
- Loss of Bone
- Loss of Teeth
- Chronic Infection
- Pain

You have also informed me that non-treatment of periodontal disease could have an adverse effect on my general health. Further, you have answered my questions concerning the suggested treatment.

I release you, unconditionally, from liability for any adverse effects I might suffer as a result of the fact that I have declined periodontal treatment as you have recommended. I accept the responsibility for the possible consequences of my refusal and accept responsibility for my dental health.

Patient Signature: ____________________________ Date: ________________