

REFUSAL OF PERIODONTAL TREATMENT

I have been advised and understand on this date that I have periodontal disease that may cause gum and bone inflammation and/or loss, and that it can lead to loss of my teeth. The severity of my condition today is slight / moderate / advanced. I have been informed that I have pocket depths as follows:

Depth	Tooth Number(s)
3-5 mm	_____
6-7 mm	_____
8+ mm	_____

Various treatment options for this condition have been explained to me, including gum surgery, replacement, extraction, as well as my right to refuse treatment. I have had the opportunity to read this form and ask questions, and my questions have been answered to my satisfaction. I am electing to refuse treatment and agree to release and hold harmless this office and the undersigned dentist from any liability for any adverse effects of my decision.

Signature of Patient/
Parent or Guardian _____

Print Name _____ Date _____

Interpreter (if used) Signature _____

Witness Signature _____

Print Name _____ Date _____

Dentist Certification:

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives (including no treatment and associated risks), to the proposed procedures. I have offered answers to any questions and have fully answered all such questions. I believe that the patient/parent/guardian fully understands what I have explained and answered.

Dentist's Signature _____

Print Name _____ Date _____