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Discussion and Refusal of Treatment

Diagnostic Radiographs (X-Rays)

Patient's Name _____ Date of Birth_____

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 6 months – 1 year). 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 which may lead 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 the least amount of exposure. (lead apron with collar and digital imaging).

I have been informed about dental radiographs, risks of x-ray exposure, and risks associated with not taking them and understand the information as described above. I have discussed my treatment with Dr. Lally/Dr. Dautaj and have been given the opportunity to ask questions and have them fully answered. Dr. Lally/Dr. Dautaj has informed me of the need for dental radiographs, risks associated with not taking radiographs. I also understand that Dr. Lally/Dr. Dautaj may refuse to treat me if I continue to refuse necessary diagnostic radiographs.

Signed: _____ Date:_____
Patient or Guardian

Signed: _____ Date:_____
Treating Dentist