REFUSAL OF RECOMMENDED ELECTIVE TREATMENT

Patient Name: _____ DOB: _____

Name of Person Completing Form (if not patient):

_____

Relationship to Patient: _____ Telephone #: _____

Date: _____ Time: _____ Location: _____

Dr. _____ has recommended that I undergo the following **elective** dental/maxillofacial test, treatment, or surgical procedure:

_____

_____

_____

Acknowledgments

I acknowledge the following:

- My oral/maxillofacial surgeon or physician has explained my medical/dental condition to me.
- The reasons for and/or the purpose of the recommended elective test/treatment/procedure have been explained to me.
- The nature of the recommended elective test/treatment/procedure has been explained to me.
- The risks and benefits of the recommended elective test/treatment/procedure have been explained to me.
- The alternatives (including non-treatment) to the recommended test/treatment/procedure have been explained to me.
- My questions have been answered in my language in a way that I can understand to my satisfaction.

Risks of Refusal

My surgeon/physician has explained the risks of refusing the recommended elective test/treatment/procedure. They include, but are not limited to:

• Gradual worsening or deterioration of my current dental, facial, or jaw condition over time.

- Future onset of pain, swelling, infection, or cyst formation in the untreated area.
- Shifting of adjacent teeth, progressive jaw bone loss, or advanced periodontal (gum) disease.
- Deterioration of facial aesthetics, bite misalignment, or functional difficulties such as chewing, swallowing, or speaking (including TMJ disorders).
- The missed opportunity for optimal surgical results, potentially leading to more extensive, riskier, and costlier future treatments.
- I understand there could be risks of refusing the recommended test/treatment/procedure that are not yet known.

Decision to Refuse

Although my refusal to follow Dr. _____'s advice and undergo the recommended elective test/treatment/procedure **could lead to a deterioration of my oral/maxillofacial health, function, or appearance, and may result in complications that are more difficult to treat later**, I choose to refuse the recommended test/treatment/procedure and accept the risks and consequences of my decision.

I understand that I can change this decision at any time by contacting Dr. _____ to re-evaluate my condition and discuss proceeding with treatment.

_____	_____
Patient Signature (or Person Completing Form)	Date
_____	_____
Witness Signature	Date
_____	_____
Surgeon / Physician Signature	Date