NORTHEAST
Dental Group

Northeast Dental Group

'A Dental Destination Location'

www.northeastdentalgroupllc.com

7770 Frontage Rd #7341

Cicero, NY 13039

INFORMED REFUSAL OF TREATMENT

I have been informed by Dr._____ of my condition and the recommended treatment consisting of_____

_____

_____

I have also been offered alternative treatments that include:_____

_____

_____

After considering the treatment possibilities offered, and having the benefits and risks of each explained to my satisfaction, I have voluntarily chosen to:_____

_____

_____

_____

_____

I understand that my decision is contrary to the treatment recommended by my doctor and that my condition may significantly worsen as a result and/or require additional therapy and/or hospitalization, and in rare circumstances may be life threatening.

I realize that I may reconsider my decision at any time by notifying my doctor.

_____

Patient's (or Legal Guardian's) Signature Date

_____

Doctor's Signature Date

_____

Witness' Signature Date