INFORMED CONSENT: Diagnostic Radiographs (X-RAYS)

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DISCUSSION AND REFUSAL OF TREATMENT

Diagnostic Radiographs (X-Rays)

Patient's Name: ______________________________ I am being provided this information and refusal form so I may fully understand the procedure recommended for the patient and the consequences of my refusal.

It has been recommended that the patient have routine diagnostic radiographs based on the American Dental Associations guidelines (a full mouth series every 3-5 years and bitewings every 1-2 years). I understand that the radiographs are necessary for the dentist to diagnose and treat possible decay (cavities), infection, fractured teeth, bone loss due to gum disease, and tumors. Without periodic radiographs, the dentist cannot identify and disclose to me potential problems, which could lead to serious jaw infections, tooth loss, and bone destruction leading 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 exposure is minimal (lead apron, collar and digital imaging). I have had an opportunity to ask questions about dental radiographs, risks of x-ray exposure, and risks associated with not taking them. I have received the above information about the proposed radiographs.

I have discussed my treatment with Dr. McNutt and have been given the opportunity to ask questions and have them fully answered. Dr. McNutt has informed me of the need for dental radiographs, risks associated with not taking radiographs, and my refusal to take radiographs.

I also understand that Dr. McNutt may refuse to treat me if I refuse necessary diagnostic radiographs.

☐ **I give my consent for the proposed treatment as described above.**

☐ **I refuse to give my consent for the proposed treatment as described above. I have been informed of the potential consequences of my decision to refuse treatment.**

Print:______________________________ Sign: ____________________ Date: _______________
Patient/Guardian

Print:______________________________ Sign: ____________________ Date: _______________
Treating Dentist

Print:______________________________ Sign: ____________________ Date: _______________
Witness