REFUSAL OF X-RAYS

I have voluntarily chosen to refuse diagnostic x-rays to help with the diagnosis and/or treatment planning of my dental condition as recommended by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has explained to me the need for x-rays, and I will not hold
Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ liable for any failure to diagnose or provide treatment which may result from my decision. I assume full responsibility for any conditions relating to my dental health that might be the result of this decision due to the lack of radiographs.

I READ AND UNDERSTAND THE ABOVE INFORMATION AND THE INFORMATION GIVEN ME VERBALLY. BY MY SIGNATURE BELOW I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

Patient Signature: Date:

Witness: Date: