INFORMED REFUSAL OF 3D DIAGNOSTIC SCAN

PATIENT'S NAME

____

LAST **FIRST**

Dr. __________________has explained my dental condition to me and has:

- Recommended a 3D diagnostic scan (Cone beam CT scan) to improve diagnosis and treatment.
- Advised me of the risks if I choose not to have the 3D scan.
- Advised me of the limitations and benefits of other x-ray options.

I understand the radiographic options available and the risks of my refusal to have the 3D diagnostic scan.

I have had the opportunity to ask questions and receive answers about my radiographic options prior to signing this form.

I DO NOT wish to proceed with the recommended 3D diagnostic scan.

____ _______________________________

Patient or Legal Representative Signature **Date**

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Patient Name

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I have personally explained the information listed above to the patient or legal representative. I am also a witness to the refusal of the recommended radiographic procedure.

____ ________________________________

Doctor or Staff Member Signature **Date**