DECLINE OF RADIOGRAPHS

I, (PRINT LEGAL GUARDIAN/PATIENT NAME)_____ decline the taking of radiographs today. I understand the importance of having x-rays taken and that a complete evaluation cannot be done without viewing updated x-rays. I, therefore, will not hold Dr._____ and Aava Dental accountable for any unforeseen treatment that may be needed and not detected without the appropriate radiographs. By signing below, I am refusing radiographs and understand and will assume any consequences.

Signature of Dentist/Professional	Date and Time
Signature of Legal Guardian/Patient	Date and Time
Signature of Witness	Date and Time

DECLINE OF TREATMENT

I, (PRINT LEGAL GUARDIAN/PATIENT NAME)_____ decline the following treatment.

Patient name if other than above:

To treat the following condition/s:

I HAVE BEEN FULLY INFORMED. THE POTENTIAL RISKS HAD BEEN EXPLAINED TO ME IN THE EVENT I DECLINE TREATMENT. I UNDERSTAND FULLY AND ACCEPT THE CONSEQUENCES OF MY DECISION TO DECLINE TREATMENT.

Signature of Dentist/Professional	Date and Time
Signature of Legal Guardian/Patient	Date and Time
Signature of Witness	Date and Time