Against Medical Advice Form Dental

Patient Information:

- **Full Name: _____**
- **Date of Birth: _____**
- **Address: _____**
- **Contact Number: _____**

Dental Clinic Information:

- **Clinic Name: _____**
- **Dentist's Name: _____**

Details of Treatment Advised:

- **Description of Recommended Treatment:**

  _____

  _____

Reason for Declining Treatment:

- **State the reason for refusing the recommended treatment:**

  _____

  _____

Acknowledgment of Risks:

I acknowledge that I have been informed of the risks and potential complications of refusing the recommended treatment, which may include:

☐ **Increased pain or discomfort**

☐ **Infection or progression of dental issues**

☐ **Loss of teeth or worsening oral health**

☐ **Other: _____**

Declaration:

I accept full responsibility for any consequences arising from my decision to decline treatment.

Patient Signature: _____ Date: _____

Dentist Signature: _____ Date: _____