GOLDEN COAST
DENTAL CARE

INFORMED REFUSAL OF DIAGNOSTIC DENTAL X- RAYS AND LIABILITY WAIVER

Date: _____

Patient Name: _____ DOB: _____

I was advised by Dr. _____ of the need for dental x-rays for the accurate diagnosis and treatment of possible dental conditions in my mouth. The doctor and/or staff have explained the importance of this diagnostic tool in the proper detection of my dental conditions and have discussed with me the potential risks on my oral health due to my refusal of the recommended x-rays.

Having been informed, I elect not to have dental x-rays at this time and hereby release and forever hold harmless Golden Coast Dental Care, Its owners and assistants and all dentists associated with my care at Golden Coast Dental Care from any responsibility or liability for any misdiagnosis of necessary treatment resulting from my refusal of x-rays. I assume full responsibility and liability for any resulting damages to my dental health that may have been detected and/or diagnosed with recommended x-rays.

Signature of Patient (Please print and sign your name) Date

Signature of Doctor Date

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