



**NEAR ME
DENTAL**

Date: ____/____/____

Informed Refusal of Necessary X-rays

Patient: _____

The Dentist has advised me to have necessary X-rays for the accurate diagnosis and treatment of possible dental conditions in my mouth. The doctor and/or staff have explained to me the importance of using the diagnostic tool and have discussed with me the potential risks of not having recommended X-rays on my oral health.

Having been informed, I elect not to have my dental X-rays at this time. I release the doctor and staff members from any responsibility resulting from my refusal.

(Patient Signature)

(Doctor/ Staff Member Signature)