PDA DENTAL GROUP
PEDIATRIC | ORTHODONTIC | ADULT

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Refusal of Dental X-Rays (Radiographs)

Patient's Full Name (please print) _____ DOB: _____

I have been made aware that routine diagnostic x-rays (radiographs) have been recommended by the doctors of PDA Dental Group for me or my child. The recommendation is based on the American Dental Association (ADA) guidelines, which advise the interval between cavity checking x-rays (bitewings) to be 1-3 years and a first panoramic x-ray when the child is in transitional dentition (typically 8-10 years of age). Future x-rays are prescribed depending on several factors including age and cavity risk.

I have chosen to refuse the recommended x-rays, which are necessary for the complete diagnosis and/or treatment of several conditions (including dental cavities, gum disease, oral trauma, infection, pathology, etc.). In doing so, I understand that I am restricting the clinician to rely only on visual/tactile means of detecting concerns (like cavities) which may be inadequate in diagnosing the presence ,extent and severity of said concerns. I have been informed that dentists are mandated to practice according to established standards of care by virtue of their licensure. Those standards of care include maintaining up-to-date x-rays.

I understand that no other reasonable alternative to dental x-rays exists at this time. I am also aware the dosage of radiation is minimal for such x-rays and that all practical precautions will be taken to ensure minimal exposure (lead apron/collar, digital imaging, and acquiring as few x-rays as possible).

I have received the above information regarding the proposed x-rays. Also, I have had the opportunity to ask the staff and doctors of PDA Dental Group about the proposed dental treatment, dental x-rays, risk of x-ray exposure and the risks associated with refusing recommended x-rays. Lastly, I understand that the doctors of PDA Dental Group will no longer be able to treat me/my child if I refuse the recommended diagnostic x-rays for a period of greater than 3 years.

I have been informed that the last dental x-rays were taken on: _____

Patient/Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____