Dr. Purnima Hernandez & Dr. Selin Soyupak
23-00 Route 208, Suite 2-5,
Fair Lawn, NJ, 07410

Informed Refusal or Necessary X-Rays

Date: _____

Patient Name: _____

Dr. _____

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 the importance of using this diagnostic tool and have discussed with me the potential risks of not having the recommended X-rays on my oral health.

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

Patient/ Parent Guardian Signature: _____