ENDODONTIC EXCELLENCE

WHERE CARING IS OUR SPECIALTY

Dr. Alan Wonhee Lee, DDS, MS
Dr. Steven Kim, DMD

11800 Sunrise Valley Drive, Suite
#250 Reston, Virginia 20191
703-429-9926
info@endoreston.com
www.endoreston.com

PATIENT OR GUARDIAN REFUSAL OF RECOMMENDED TREATMENT

I understand that the following treatment, medication, or examination was recommended by our doctor(s):

_____

By signing this form, I certify that I was explained the nature, purpose, anticipated benefits, material risks, possible complications, and alternatives to the proposed procedure/treatment and the risks and consequences of not proceeding by our doctors(s). All questions were answered fully, and I fully understand what was explained.

I am aware that this refusal is against the advice of our doctor(s). I am also aware of the risks associated with this action, including the fact that my condition may worsen.

I hereby release our doctor(s) and his staff from all responsibility for all ill effects that may result from my refusal of treatment, medication, examination, or procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

_____ _____ _____

Patient Name | Signature of Patient or Legal Guardian | Date