Pediatric Dentistry
Orthodontics
TRUPKIN • WILENTZ • CHIZNER

INFORMED CONSENT FOR SILVER DIAMINE FLUORIDE TREATMENT

The permission of a parent or legal guardian is necessary for dental treatment of a minor before any treatment can be started or completed by our office. While signing this form gives consent for us to treat your child, we encourage you to speak to any of our staff members, especially the Doctor, if you have any questions regarding your child's specific needs or treatment being provided.

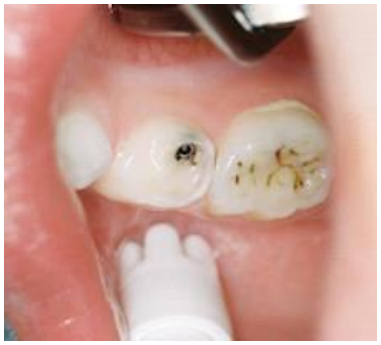
Silver Diamine Fluoride is a medication that is applied to an active area of decay (cavity) to kill the bacteria causing the cavity, prevent the formation of a plaque layer on the treated surface, and strengthen the tooth.

It is very important that you are made aware that treating cavities with this medicine will cause color changes to the lesions (cavity). The areas of the tooth with active dental decay will turn dark black as the medicine is working. The healthy areas of the tooth will not be effected and will remain your child's natural tooth color. The black color indicates that the treatment is successful. If your child gets any of this medicine on their skin, the skin could be discolored temporarily. Please keep your child's fingers out of their mouth after treatment.

It is also important that you are aware that this medicine will treat the bacteria causing tooth destruction, but will not restore the tooth structure that has already been effected by the disease process. Your child will still require restoration of the teeth (fillings, crowns and possibly nerve treatment) if there is any loss of tooth structure. The Doctor and our team will discuss the recommended timing of this treatment, and will discuss the best way to provide this treatment to ensure that your child receives treatment in the least invasive, most predictable and least traumatic way possible. You will sign a separate treatment plan for the actual restoration (filling, crown and/or nerve treatment) of your child's teeth.

As a parent or legal guardian of the above patient, I grant the treating Doctor and Pediatric Dentistry and Orthodontics permission to provide my child's dental treatment as discussed. I also understand that this treatment may not be covered by my insurance (if applicable) and any estimates of insurance coverage discussed by any staff member at Pediatric Dentistry and Orthodontics was provided to me as courtesy. It is my responsibility to contact my child's dental insurance company (including any insurance provided to my child by the state) to discuss and understand my child's policy.

I agree to inform the treating Doctor and the staff of Pediatric Dentistry and Orthodontics of any changes in the patient's medical history. This authorization is valid until revoked by me in writing.



Sample picture of teeth treated by Silver Diamine Fluoride

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Parent/Guardian's Signature Name of patient receiving treatment

_____ _____

Today's Date Witness's Signature