Consent for Silver Diamine Fluoride with Fluoride Varnish Therapy to Arrest Decay

The use of silver diamine fluoride in dentistry has been well documented for its safe and successful ability to control tooth decay. Its application is a conservative approach for the treatment of active decay.

The Procedure:

- Dry teeth
- Application of 38% Silver Diamine Fluoride (FDA approved product) to appropriate teeth with visible cavities in very small amounts using a micro brush.
- Application of 5% Sodium Fluoride varnish (FDA approved product) used to seal Silver Diamine Fluoride into the treated tooth and to arrest the decay in the tooth.
- Home Fluoride Therapy

Contraindications:

- Silver Diamine Fluoride Allergy (very rare)

Possible Side Effects:

- A cavity in the presence of Silver Diamine Fluoride will turn that part of the tooth dark. This is an indication that the decay in the tooth is arresting.
- If Silver Diamine Fluoride comes in contact with skin and/or gums, temporary discoloration will occur.
- If Silver Diamine Fluoride is placed on a tooth that has a tooth colored restoration on it, discoloration may occur.
- Silver Diamine Fluoride placed on demineralized enamel (white lesions) may cause discoloration.

The side effects listed above may not include all of the side effects reported by the drug's manufacturer. If you notice other effects not listed above, please contact us.

Treatment of tooth decay with Silver Diamine Fluoride does not necessarily prevent the need to place a regular filling in the affected tooth in the future in order to restore function and esthetics.

Do not eat for one hour and do not brush your teeth for 24 hours after treatment.

The above treatment technique has been explained to* me *to my satisfaction and I understand it fully. I have read this form, understand the treatment, have had the risks, benefits, and alternative treatments explained, and have had the chance* to *ask questions. I understand that I may refuse treatment. 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 was provided to me as courtesy. It is my responsibility to contact my child's dental insurance company to discuss and understand my child's policy.

Patient Name: _____

No warranty or guarantee has been made as to the result or cure. It has been explained to me and I understand the consequences which may affect my child's health if dental treatment is not performed.

Print Name of Parent or Legal Guardian: _____ Date: _____

Signature of Parent of Legal Guardian: _____ Date: _____