CONSENT FORM FOR TREATMENT OF CAVITIES WITH ADVANTAGE ARREST (SILVER DIAMINE FLUORIDE 38%)

Patient : ____

Parent: ____

Date : ____________________

1. I, __________________________, authorize and request Dr. Elizabeth Crespi to treat my child's cavities with **Advantage Arrest (Silver Diamine Fluoride 38%).** I acknowledge that I've given Dr. Crespi a thorough medical history and my child does not have an allergy or sensitivity to heavy-metals.

2. I also authorize and direct my doctor(s), with associates or assistants of his (their) choice, to provide such additional services as he (they) may deem reasonable and necessary, including, but not limited to, the administration of anesthetic agents, the performance of necessary laboratory, radiological (x-ray), and other diagnostic procedures; and the administration of medications orally, by injection, by infusion, or by any other dentally accepted route of administration. If an unforeseen condition arises in the course of treatment which calls for the performance of procedures in addition to or different from that now contemplated I further authorize and direct my doctor(s), with associates or assistants of his(their) choice, to do whatever he (they) deem necessary and advisable under the circumstances, including the decision not to proceed with the treatment.

3. Alternatives to Silver Diamine fluoride have been explained to me, including their risks. I have considered these alternatives to treatment and their risks but I request the Silver Diamine fluoride application. **I understand that Silver Diamine Fluoride will turn my child's cavities black in color and have been showed pictures of previously treated patients and what the teeth looked like after treatment. I understand that this product can cause reversible, short-term irritation of my child's teeth and gums.**

4. **I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of this treatment. I understand that my child may require additional treatment in the future including, but not limited to fillings, root canals, crowns and other procedures. I understand that this is a procedure recommended for young and/or apprehensive patients that may not be able to cooperate for lengthy/complex dental procedures.**

5. **The Silver Diamine Fluoride Application Procedure has been explained to me and I understand the nature of these procedures as follows:**

   Silver Diamine Fluoride will be applied for two minutes to each of my child's cavities. The Silver Diamine Fluoride has been shown to arrest (halt or slow down) dental cavities in order to minimize children's discomfort and potential further progression of their cavities. I understand that the traditional way to manage cavities is to surgically remove them using a dental drill followed by filling of the cavity to restore the function and esthetics of the tooth.

6. As with any dental procedure, there are possible complications of which you must be aware. These include, but are not limited to: limited oral function; post operative pain; bleeding; infection or abscess which may require treatment or drainage; temporary bruising of the face, allergic reactions to metal and medications; a change in sensation or numbness to the lip, chin, face and/ or tongue which may be of a temporary or permanent nature; periodontal infection or condition requiring additional treatment; injury to the teeth; temporomandibular joint (jaw) problems requiring additional treatment and poor healing which may result in an alteration or change in the planned treatment.

7. **I understand I have had an opportunity to ask and have my questions answered. I understand my insurance will not cover this procedure and I am responsible for all dental treatment regardless of my insurance plan.**

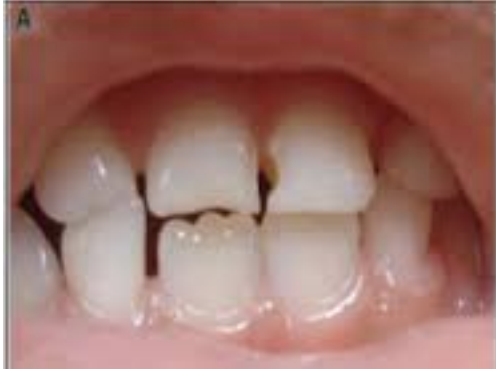
8. I certify that I have read, have had explained to me, and fully understand the Silver Diamine Fluoride Application procedure and that it is my intention to have the foregoing carried out as stated. I have been advised of information concerning the need for further treatment in the future. However, I have discussed this as well as the nature of the services and procedures and I consent to the Silver Diamine Fluoride Application knowing its risks and limitations.

9. I represent that I have the legal authority to authorize all dental treatment to be rendered for the above child. I will immediately inform the office should this authority change or require consent from any other party.

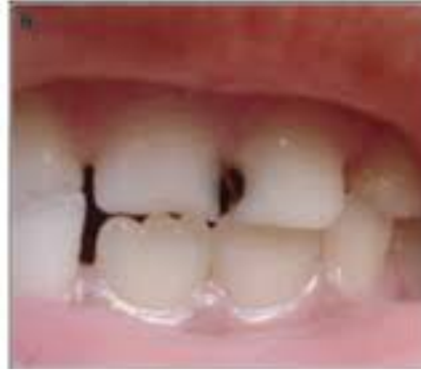
Witness (if available): ____

Parent/Guardian: ____

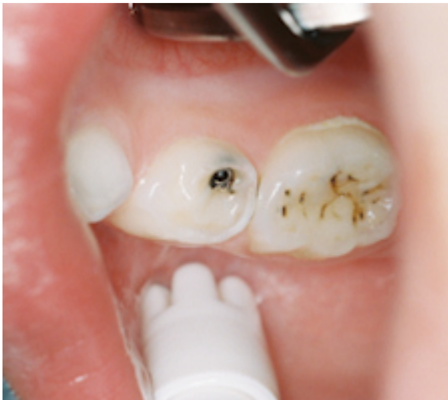
Dated : ______________________________ **Time :** ________________________



Cavities before treatment



Cavities after treatment



Cavities on molars (after treatment)

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