



Public Health
Clinic Operations

PRIMARY CARE GENERAL CONSENT

1. This is to certify that I, the undersigned (and/or my child), have insurance coverage with _____, and hereby consent to receive healthcare services for myself and/or my child from the San Bernardino County Department of Public Health.
2. The information that I provided for myself or for my child, _____ is true to the best of my knowledge. I understand that my (or my child's) health information is given in advance of medical evaluation and treatment.
3. I understand that routine healthcare is voluntary and may involve provider office visits which include history taking, physical examinations, laboratory or radiologic tests; prescription medications and/or immunizations; mental health evaluation, counseling and/or treatment; and/or medical procedures. I also understand that I (or my child) may be referred to another medical facility for additional care and treatment.
4. I wish to continue my healthcare with the San Bernardino County Department of Public Health until I revoke this Primary Care General Consent in writing. I understand that I am financially responsible for all medical charges whether or not paid by my insurance unless services are provided by a sponsored mobile unit event.
5. I understand that all information shared with my healthcare provider(s) is confidential and that no information will be released to external entities without my consent or when permitted by law and/or medically necessary. I understand that my healthcare provider may request pertinent medical/mental health records from my previous provider(s) to assist in providing continuous healthcare. I acknowledge that the San Bernardino County Department of Public Health will use and disclose my (or my child's) medical and/or mental health information for the purposes of treatment, payment, prescriptions, and healthcare operations.

Your initials: _____

6. I understand that photographs may be taken for treatment purposes.

Your initials: _____

I acknowledge that I have been given the San Bernardino County Department of Public Health Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Officer.

Your initials: _____



PRIMARY CARE GENERAL CONSENT

MEDICARE CLIENTS: I authorize the release of medical/mental health information about me to the Social Security Administration (SSA) or its intermediaries for my Medicare claims. I assign the benefits payable for services to San Bernardino County Department of Public Health.

Your initials: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature: _____ Date: _____

Staff Signature/Title: _____ Date: _____

WITHDRAWAL OF CONSENT FOR CARE AND TREATMENT

I, _____ (patient or representative)
withdraw this consent, effective on _____.

Patient Signature: _____ Date: _____

(Or responsible party signature)

Patient Name: _____

DOB: _____

Patient Number: _____



Public Health
Clinic Operations

Patient Name: _____

DOB: _____ Patient Number: _____

BP: _____ Pulse: _____

CONSENT FOR DENTAL TREATMENT

Planned Treatment:

I understand that I am having the following treatment done:

- Nonsurgical Periodontal Treatment
- Root Canal Treatment
- Crown or Bridge

- Fillings
- Extraction(s)
- Other: _____

Patient's initials required below:

Drugs and Medications:

_____ I understand antibiotics and analgesics (pain medications) can cause allergic reactions resulting in redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Changes in Treatment Plan:

_____ I understand during treatment it may be necessary to change or add procedures because of conditions found while working on the tooth (teeth) that were not discovered during examination, the most common being root canal treatment following routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary.

Crowns and Bridges (Caps):

_____ I understand sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crown(s), which may come off easily and I must follow instructions regarding home care to ensure they are kept on or return to re-cement them until the permanent crowns or bridge are delivered.

Dentures - Complete, Partial, Interim (Immediate):

_____ I understand full or partial dentures are artificial, constructed or plastic (acrylic), metal, and/or porcelain. I understand immediate/interim dentures are a temporary appliance and will require a new, permanent set made (complete or partial denture). The risks, benefits and alternatives to denture treatment have been explained to me including looseness, soreness, possible breakage, and relining due to tissue changes.

Periodontal loss/disease (Tissue and Bone):

_____ I understand I have a serious condition causing gum and bone inflammation or loss that may lead to tooth/teeth loss and other complications. The alternative treatment plans have been explained to me including gum surgery, replacement (grafts), and/or extractions. I understand although these treatments have a high degree of success, it cannot be guaranteed. Occasionally, treated teeth may require extraction.



DENTAL CARE GENERAL CONSENT

1. This is to certify that I, the undersigned (and/or my child), have insurance coverage with _____, and hereby consent to receive dental care services for myself and/or my child from the San Bernardino County Community Health Center Primary Care Clinics.
2. The health information that I provided for myself or for my child, _____ is true to the best of my knowledge. I understand that my (or my child's) health information is given in advance of medical/dental evaluation and treatment.
3. I understand that routine health/dental care is voluntary and may involve provider office visits which include history taking, physical examinations, laboratory or radiologic tests; prescription medications and/or immunizations; counseling and/or treatment; and/or medical/dental procedures. I also understand that I (or my child) may be referred to another medical/dental facility for additional care and treatment.
4. I wish to continue my dental care with the San Bernardino County Mobile Health Clinics until I revoke this Dental Care General Consent in writing. I understand that I am financially responsible for all medical/dental charges whether or not paid by my insurance according to the policies of the San Bernardino County Mobile Health Clinics.
5. I understand that all information shared with my health/dental care providers is confidential and that no information will be released to external entities without my consent or when permitted by law and/or medically necessary. I understand that my health/dental care provider may request pertinent medical/dental/mental health records from my previous provider to assist in providing continuous health/dental/mental care. I acknowledge that the San Bernardino County Mobile Health Clinics will use and disclose my (or my child's) medical, dental and/or mental health information for the purposes of treatment, payment, prescriptions, and healthcare operations as described in the San Bernardino County Department of Public Health Notice of Privacy Practices.
Your initials: _____
6. I understand that photographs may be taken for treatment purposes.
Your initials: _____

I acknowledge that I have been given the San Bernardino County Department of Public Health Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Officer or designee.
Your initials: _____



DENTAL CARE GENERAL CONSENT

MEDICARE CLIENTS: I authorize the release of medical/dental/mental health information about me to the Social Security Administration (SSA) or its intermediaries for my Medicare claims. I assign the benefits payable for services to San Bernardino County Mobile Health Clinics.

Your initials: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature: _____ Date: _____

Staff Signature/Title: _____ Date: _____

WITHDRAWAL OF CONSENT FOR CARE AND TREATMENT

I, _____ (patient or representative)
withdraw this consent, effective on _____.

Patient Signature: _____ Date: _____

(Or responsible party signature)

Patient Name: _____

DOB: _____

Patient Number: _____



Public Health
Clinic Operations

Patient Name: _____

Patient Medical Number: _____

DOB: _____ Weight: _____

Diagnosis: _____

Treatment: _____

Informed Consent for Anesthesia/Sedation

The purpose of this informed consent/refusal form is to ensure that your dentist is conforming to California laws and regulations; to provide you, the patient, information regarding your condition(s), recommended treatment and associated risks, benefits, and alternatives to proposed treatment(s). This document will become part of your dental record.

Option 1: Local Anesthesia

Anesthetizing agents (medications) are injected into a small area with the intent of numbing the area to receive dental treatment. They also can be injected near a nerve to act as a nerve block causing numbness to a larger area of the mouth beyond just the site of injection.

Risks include but are not limited to: It is normal for the numbness to take time to wear off after treatment, usually two or three hours. This can vary depending on the type of medication used. However, in some cases, it can take longer, and in some rare cases, the numbness can be permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, dizziness, nausea, vomiting and cheek, tongue or lip biting can occur.

Potential benefits: The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during the dental treatment.

Option 2: Nitrous Oxide/Oxygen Inhalation Sedation

Nitrous oxide/oxygen (N₂O) inhalation is a mild form of conscious sedation used to calm an anxious patient. The patient is observed while N₂O is administered and after the completion of treatment until the patient is fully recovered from its effects.

Risks include but are not limited to: An early effect may be disorientation and temporary numbness and tingling. Nausea and vomiting may occur infrequently. If the patient will not accept wearing the N₂O mask during treatment, nitrous oxide/oxygen cannot be used.

Potential benefits: The patient remains awake and can respond to directions and questions. N₂O helps overcome apprehension, anxiety or fear.

Option 3: Conscious Sedation

Conscious sedation is a controlled, drug-induced, minimally depressed level of consciousness or awareness that allows the patient to breathe independently and continuously respond appropriately to physical stimulation and/or verbal command, e.g., "open your eyes."

Local anesthetic is still required to numb the area of treatment. This type of anesthesia may be administered orally (a drink or a pill), injected into a muscle or by a needle inserted into a vein.

Risks include but are not limited to: Infection, swelling, discoloration, bruising, headache, tenderness at the needle site and vein (phlebitis), dizziness, nausea and vomiting can occur. Adverse reactions to medication, including allergic and life-threatening reactions, are possible though rare. Complications may require hospitalization or even result in brain damage or death. With any patient, reflexes are delayed. Children: Patients can have an immediate response to oral conscious sedation similar to being upset before the medication calms them. Adults: Patients must not drive a car or operate machinery for 24 hours after the termination of treatment, because the effects of sedation remain in the system even after the patient is awake and mobile.

Potential benefits: Pain is lessened or eliminated during dental treatment. Stress and anxiety can be greatly reduced and often there is no memory of the treatment.



Public Health
Clinic Operations

Patient Name: _____

Patient Medical Number: _____ DOB: _____

Diagnosis: _____

Treatment and Tooth #s: _____

Informed Consent for Filling(s)

The purpose of this informed consent/refusal form is to ensure that your dentist is conforming to California laws and regulations; to provide you, the patient, information regarding your condition(s), recommended treatment and associated risks, benefits, and alternatives to proposed treatment(s). This document will become part of your dental record.

I understand that by signing below, I am authorizing the procedure(s) to be performed and I have read and understand the entirety of this form, including the possible risks and complications of the chosen procedure(s) and the available alternatives.

Fillings:

Fillings are used to protect a sensitive surface of the tooth, to replace tooth structure, relieve pain, cover an eroded area and fill in a hole or space in the tooth structure.

I understand that care must be exercised in chewing after the placement of fillings, especially during the first 24 hours, to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay present at the time of treatment. Following a filling, there may be sensitivity of the teeth that can last for a short period of time. If the sensitivity continues, I will notify the dentist as this can be a sign of more serious problems. During the preparation for a filling, the removal of tooth structure may lead to exposure of trauma to underlying nerve or pulp tissue. Extreme sensitivity or possible abscess often indicate that the pulp did not heal. If that is the case, a root canal treatment or extraction may be required. Because of extreme masticatory (chewing) pressures or other traumatic forces, it is possible for fillings to become dislodged or fracture. The resin-enamel bond that adheres the filling material to the tooth structure can also fail, resulting in leakage and recurrent decay.

I understand that delaying treatment may cause harm, the dental disease may progress, further damage to teeth may occur and swelling and infection may occur creating additional treatment and associated expenses.

Local Anesthesia:

In connection with my dental work, local anesthetic may be used for pain control during dental procedures. All anesthetics create risks and possible side effects. These include, but are not limited to, swelling, bruising, soreness, elevated blood pressure or pulse, allergic reaction and altered sensation that may lead to biting the lip or tongue. Partial or complete numbness may linger after the dental appointment. In rare cases, it can last for an extended time and occasionally may be permanent.

Types of available fillings:

1. **Composite** (tooth-colored filling): Resin or white fillings have an advantage of allowing a more "conservative" tooth preparation, can have a strengthening effect on the tooth, have improved aesthetics and blend in with the natural tooth. Risks involved with a composite filling include, but are not limited to, sensitivity of teeth, risk of fracture lines in the tooth structure, necessity for root canal therapy, injury to the nerves, shade variation of the filling, alteration in speech, breakage, dislodgement or bond failure because of pressures or other traumatic forces.
2. **Amalgam** (silver and mercury containing): Mercury has been used for decades as a component of filling material for teeth. In recent years, however, some opponents to the material have asserted that there is a possibility, although unproven, that silver amalgam may have an effect on the general health of a person due to its mercury content. Occasionally shavings generated by placement or carving of silver amalgam fillings may work their way within the surrounding oral tissues and become lodged. Over an extended period, gray spots or "tattoos" may become visible within the mouth.



Public Health
Clinic Operations

Patient Name: _____

Patient Medical Number: _____ DOB: _____

Diagnosis: _____

Treatment: _____

Quadrants: _____

Informed Consent for Nonsurgical Periodontal Treatment

The purpose of this informed consent/refusal form is to ensure that your Dentist is conforming to California laws and regulations; to provide you, the patient, information regarding your condition(s), recommended treatment and associated risks, benefits, and alternatives to proposed treatment(s). This document will become a part of your dental record.

Benefits of nonsurgical periodontal treatment, not limited to the following:

Periodontal (gum) treatment is intended to remove the bacterial substance known as plaque, which is the principal cause of gum disease, and the hard mineral deposits called calculus from above and below the gum line. The treatment involves scaling, which uses hand instruments to remove plaque and calculus from the tooth and root surfaces are then smoothed. Medications or a special mouth rinse can be used to help control the growth of bacteria and may be part of treatment.

Regular, professional dental cleanings create a clean environment in which your gums can heal, reduce the chances of further irritation and infection, make it easier for you to keep your teeth clean and decrease the cost of replacing teeth lost due to gum disease.

Risks of nonsurgical periodontal treatment, not limited to the following:

I understand that one of the effects of treatment is that my gums may bleed or swell and I may experience moderate discomfort after the anesthesia wears off. There may be soreness for a few days, which may be treated with pain medication. I will notify the Dentist if conditions persist beyond a few days.

I understand that because cleanings involve contact with bacteria and infected tissue in my mouth, I may also experience an infection that may require treatment with antibiotics or other therapies.

I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days, sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problem. In the event this occurs, I must notify the Dentist if I experience persistent trismus or other similar concerns arise.

I understand that after treatment, as my gum tissues heal they may shrink somewhat, exposing some of the root surface. This could make my teeth more sensitive to hot or cold. I understand that additional surgical procedures may be needed to treat the exposed areas.

I understand that depending on my current dental condition, existing medical problems or medications I may be taking, these periodontal treatment methods alone may not completely reverse the effects of gum disease or prevent further problems.

I understand that I may receive a topical or local anesthetic and/or other medication as part of my treatment. In rare instances, patients may have a reaction to the anesthetic, which could require emergency medical attention. Rarely, temporary or permanent nerve injury causing numbness or pain of the lip, chin, cheek, teeth, or tongue may result from an injection.

I understand that ALL medications have the potential for risks, side effects, and drug interactions. Therefore, it is critical that I tell the Dentist of all medications and supplements I am currently taking, which are: _____

I understand that smoking can adversely affect the outcome of the periodontal therapy suggested and that final results of periodontal therapy may be minimal or negated because of my history or lack of smoking cessation.

I understand that the long term success of the treatment depends in part of my efforts to brush and floss daily, receive regular cleanings as directed, follow a healthy diet, avoid tobacco products and follow proper home care instructions taught by my provider(s).



Public Health
Clinic Operations

Patient Name: _____

Patient Medical Number: _____ DOB: _____

BP: _____ Pulse: _____

Diagnosis: _____

Tooth Number(s)/Area(s): _____

Informed Consent for Oral Surgery (Extractions)

The purpose of this informed consent/refusal form is to ensure that your Dentist is conforming to California laws and regulations; to provide you, the patient, information regarding your condition(s), recommended treatment and associated risks, benefits, and alternatives to proposed treatment(s). This document will become part of your dental record.

Benefits of extraction, not limited to the following:

The proposed treatment is intended to help relieve your symptoms and may also enable you to proceed with further proposed treatment.

Risks of extraction, not limited to the following:

I understand that following treatment I may experience bleeding, pain, swelling, and discomfort for several days, which may be treated with pain medication. It is possible infection can follow extraction and must be treated with antibiotics or other procedures. I will contact the Health Center immediately if symptoms persist or worsen.

I understand that I will receive a local anesthetic and/or other medication. In rare instances, patients have a reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing foreign objects during treatment. **Depending on the anesthesia and medications administered, I may need a designated driver to take me home.** Rarely, temporary or permanent nerve injury to the oral cavity and face can result from an injection resulting in numbness of the lip, chin, cheek, gums, teeth or tongue, including loss of taste.

I understand that ALL medications have the potential for risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications and supplements I am currently taking, which are: _____

I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days; this is sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problem. In the event this occurs, I must notify the Health Center if I experience persistent trismus or other similar concerns arise.

I understand that the necessary blood clot that forms in the socket may disintegrate or dislodge. This painful condition, called dry socket, lasts a week or more and is treated by placing a medicated dressing in the tooth socket to aid healing. To protect against developing dry socket, I must not smoke tobacco or marijuana, drink through a straw, rinse with water or mouthwash, chew food in that area or disturb the socket in any way for 24 to 48 hours. Smoking may adversely affect the extraction site healing and may cause dry socket (an infection of the bone of the socket walls). Smokers are at higher risk for dry socket and have more dry sockets than nonsmokers.

I understand that the instruments used in extracting a tooth may unavoidably chip or damage adjacent teeth, which could require further treatment to restore their appearance or function.

I understand that upper teeth have roots that may extend close to the sinuses. Removing these teeth may temporarily leave a small opening into the sinuses. Antibiotics and additional treatment may be needed to prevent a sinus infection and help this opening to close. If such a complication occurs, I may require additional treatment by a physician or an oral and maxillofacial surgeon.

I understand that an extraction may cause a fracture in the surrounding bone. Occasionally, the tooth to be extracted may be fused to the surrounding bone. In both situations, additional treatment is necessary. Bone fragments called "spicules" may arise at the site following extraction and are generally easily removed.

I understand that tooth fragments may be left in the extraction site following treatment due to the condition and position of the tooth/teeth. Generally, this causes no problems, but on rare occasions the fragments can become infected and subsequently must be removed.

I understand that the nerves that control sensations in my teeth, gums, tongue, lips and chin run through my jaw. Depending on the tooth to be extracted (particularly lower teeth or third molars), occasionally it may be difficult or impossible to avoid touching, moving, stretching, bruising, cutting, or severing a nerve. This could change the normal sensations in any of these areas causing itching, tingling, or burning, or the loss of all sensation, including numbness of the chin, cheeks, lips, gums, or tongue and the loss of taste. These changes could last from several weeks to several months or, in some cases, indefinitely or permanently.

Consequences if no treatment is administered, not limited to the following:

I understand that if no treatment is performed, I may continue to experience symptoms, which could include pain and/or infection, deterioration of the bone surrounding my teeth, changes to my bite, discomfort in my jaw joint, and possibly the premature loss of other teeth.

Alternatives treatments if extraction is not the only solution, not limited to the following:

I understand that depending on my diagnosis, alternatives to extraction may exist that involve other disciplines in dentistry including endodontics (root canal treatment). I asked my dentist about them and their respective costs. My questions have been answered to my satisfaction regarding the procedures and their risks, benefits and costs.

Alternatives discussed: _____

No guarantee of assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

Initial everything below that applies to you:

Consent

- _____ I have been informed, both verbally and by the information provided on this form, of the risks and benefits of the proposed treatment.
- _____ I have been informed, both verbally and by the information provided on this form, of the material risks and benefits of alternative treatment and of electing not to treat my condition.
- _____ I certify that I have read and understand the above information that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct the Dentist to do what he/she deems necessary and advisable under the circumstances.
- _____ I consent to have the above above-mentioned treatment.
- _____ While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

OR

Refusal

_____ I refuse to give my consent for the proposed treatment(s) as described above and understand the potential consequences associated with this refusal.

Patient or Parent/Legal Guardian (print name)	Signature	Date
Witness (print name)	Signature	Date
Dentist (print name)	Signature	Date

I attest that I have discussed the risks, benefits, and consequences associated with treatment as well as the risk and benefits of alternative treatment with the patient. The patient has had the opportunity to ask questions and I believe the patient understands what has been explained and willingly consents to the treatment discussed herein.



Public Health
Clinic Operations

Patient Name: _____

Patient Medical Number: _____ DOB: _____

Diagnosis: _____

Tooth Number(s)/Area(s): _____

Informed Consent for Root Canal Retreatment

The purpose of this informed consent/refusal form is to ensure that your Dentist is conforming to California laws and regulations; to provide you, the patient, information regarding your condition(s), recommended treatment and associated risks, benefits, and alternatives to proposed treatment(s). This document will become part of your dental record.

Benefits of canal retreatment, not limited to the following:

Root canal retreatment is intended to correct a condition that developed after the initial root canal treatment or did not resolve after your initial root canal treatment to allow you to keep your tooth for a longer time, which will help to maintain your natural bite and the healthy functioning of your jaws. This treatment may also be recommended to relieve the symptoms of the diagnosis described above.

Risks of root canal retreatment, not limited to the following:

I understand that following treatment I may experience bleeding, pain, swelling and discomfort for several days, which may be treated with pain medication. It is possible infection may accompany root canal retreatment and must be treated with antibiotics. I will immediately contact the Health Center if conditions worsen or if I experience fever, chills, sweats, numbness, sinus problems, severe pain, or swelling.

I understand that I may receive a local anesthetic and/or other medication. In rare instances, patients have a reaction to the anesthetic or find that it reduces their ability to control swallowing, which may require emergency medical attention. Lack of control of swallowing increases the chance of swallowing foreign objects during treatment. **Depending on the anesthesia and medications administered, I may need a designated driver to take me home.** Rarely, temporary or permanent nerve injury causing numbness of the oral cavity and or face including the lips, chin, cheeks, gums, teeth, or tongue, including loss of part of the sense of taste, can result from an injection.

I understand that ALL medications have the potential for risks, side effects, and drug interactions. Therefore, it is critical that I tell the Dentist of all medications and supplements I am currently taking, which are: _____

I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days; this is sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problem. In the event this occurs, I must notify the Health Center if I experience persistent trismus or other similar concerns arise.

I understand that occasionally a root canal instrument may break off in a root canal that is twisted, curved, or blocked with calcium deposits. Depending on its location, the fragment may be retrievable or it may be necessary to seal it in the root canal (these instruments are made of sterile, nontoxic surgical stainless steel and usually cause no harm). It may also be necessary to perform an apicoectomy, as described above, to seal the end or lower part of the root canal.

I understand that during treatment the root canal filling material may extrude out the root canal into the surrounding bone and tissue. Occasionally, an apicoectomy may be necessary for retrieving the filling material and sealing the root canal.

I understand that other complications that may occur include, but are not limited to, perforations (extra openings) of the canal by an instrument, blocked root canals that cannot be ideally cleaned and filled, fracture, chipping, or loosening of existing tooth or crown, requiring replacement at an additional cost. I may also experience temporary or permanent numbness or painful nerve sensations.

I understand teeth that receive root canal treatment may be more prone to cracking and breaking over time and teeth may require removal and replacement with a bridge, partial denture or implant. In some cases, root canal retreatment may not relieve all symptoms.



Public Health
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Patient Name: _____

Patient Medical Number: _____ DOB: _____

Informed Consent for Silver Diamine Fluoride (SDF)

Silver diamine fluoride (SDF) is an antimicrobial liquid. SDF can be used to treat cavities to help stop tooth decay. SDF can also be used to treat tooth sensitivity. SDF application every six to 12 months, but may be applied as necessary at a frequency determined by the Dentist.

The procedure:

Step	Action
1	Drying the affected area.
2	Placing a small amount of SDF on the affected area.
3	Allowing SDF to dry for one minute.
4	Rinsing the area with water.

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Figure 1. Primary Incisors Before SDF treatment.

Figure 2. Primary Incisors After SDF treatment.

Note: Treatment with SDF does not eliminate the need for dental fillings or crowns to repair function or esthetics.

Benefits of receiving SDF:

- SDF can help stop tooth decay.
- SDF can help relieve sensitivity.

Risks related to SDF include, but are not limited to:

- The affected area will stain black permanently. Healthy tooth structure will not stain. Stained tooth structure can be replaced with a filling or a crown.
- Tooth-colored fillings and crowns may discolor if SDF is applied to them. Color changes on the surface can normally be polished off. The edge between a tooth and filling may remain stained.
- If accidentally applied to the skin or gums, a brown or white stain may appear that causes no harm, cannot be washed off and will disappear in one to three weeks.
- You may notice a metallic taste. This will go away rapidly.

These side effects may not include all of the possible situations reported by the manufacturer. If you notice other effects, please talk with your dental provider.

Patients should not be treated with SDF if:

- Allergic to silver.
- There are painful sores or raw areas on gums (i.e. ulcerative gingivitis) or anywhere in the mouth (i.e., stomatitis).

Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that the procedure will not stop the decay and no guarantee of success is granted or implied. If tooth decay is not arrested, the decay will progress. In that case, the tooth will require further treatment, such as repeat SDF, a filling or crown, root canal treatment, or extraction.

If you decide not to have the SDF application for your child, it may result in continued deterioration of tooth structures. Symptoms may increase in severity. Alternatives to SDF application include but are not limited to the following:

- Use of repeated applications of fluoride varnish or other antimicrobials (e.g., chlorhexidine) to limit the progression of tooth decay.
- Depending on the extent of decay, placement of a filling or crown or extraction of the affected tooth, which may require advanced treatment modalities such as sedation or general anesthesia.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT. ALL OF MY QUESTIONS WERE ANSWERED:

Patient or Parent/Legal Guardian (print name)	Signature	Date
Witness (print name)	Signature	Date

