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Informed Consent for Silver Diamine Fluoride

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

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 child's 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 insurance benefits.

No warranty or guarantee has been made as to the result or cure. I understand that my child's diet and oral hygiene will influence the results and protection from future decay. It has been explained to me and I understand the consequences which may affect my child's health if dental treatment is not performed.
Occasionally more than one SDF treatment is needed. I understand a follow-up appointment is recommended in 3 months.

Date: _____

Signed by legal guardian:_____

Patient Name:_____