Doctor's Name _____

Address _____

Phone _____

I, _____ , give my dentist. Dr. _____ , permission to remove my silver-amalgam dental restorations and other non-precious metals from my teeth and replace them with dental materials which he considers to be biocompatible based on existing scientific research. These materials include: posterior composite resins; ceramic; porcelain; and gold.

I have been provided with written material on silver/mercury dental restorations. Any questions that were not answered with the written material were subsequently answered by Dr. _____

Dr. _____ has explained to me that:

1. Although one or more of my subjective or objective signs or symptoms may resemble the signs or symptoms of mercury toxicity, I understand that this does not mean that I am suffering from the effects of mercury toxicity either directly or indirectly.
2. There is no scientific evidence that removal of silver/mercury fillings will cure or improve any signs, symptoms, problems or conditions I have.
3. Any sign, symptom, problem or condition I have outside the mouth may involve a general health or medical question. My dentist is limiting advice to my oral conditions, and recommends that I consult a physician for any general health or medical concerns or questions I have. Further, my dentist has not told me or represented to me that replacing my mercury/silver fillings or non-precious metal restorations would have any effect on me at all.

If a posterior composite resin is the material chosen to replace silver/mercury and other non-precious materials, the advantages and disadvantages of the material chosen have been explained to me, including the fact there has not been a sufficient number of years of use to scientifically prove its wear characteristics. Accordingly, at this time, it is not known if posterior restorations may have to be replaced more frequently.

As might occur with the placement of silver amalgam, gold, or any other dental material, I understand there are situations beyond the control of my dentist that may necessitate endodontic treatment or removal of a tooth despite precautions taken and proper procedures utilized.

My questions concerning the treatment plan recommended by Dr. _____, and agreed to by me have been fully answered and I have read this statement and fully understand it.

Signature: _____ Signature: _____

Patient Witness

Date: _____

I, _____ , hereby authorize Dr. _____ and employees and such assistants as may be selcted, to treat the condition(s) described on the treatment plan. (Treatment Plan Attached)

Please read each paragraph. If it is clear and you understand and have no further questions regarding the statement, then please record your initials by each statement.

Initial _____ The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure(s) to be done. (see treatment plan)

Initial _____ I have been informed of possible alternative methods of treatment (if any), including no treatment at all and the risks of non-treatment.

Initial _____ I further understand that this is an elective procedure and other forms of treatment or no treatment, are all choices I have. I understand this treatment is intended to provide me with an optimally restored mouth with biocompatible materials. The International Conference on the Biocompatibility of Materials (1.C.B .M., Nov.5-10, 1988) declares that "based on known toxic potentials of mercury and its documented release from dental amalgams, usage of mercury-containing dental amalgam increases the health risk to the patients, the dentists, and dental personnel."

Dr. □_____
treatment suggestion(s) or procedure(s), and in this specific instance, such treatment risks include, <u>but are not limited</u> to the following:

Initial _____ A. Postoperative discomfort and swelling which may necessitate several days of home recuperation.

Initial _____ B. Some bleeding around the gums.

Initial _____ C. Sensitivity - It is generally normal for teeth to be sensitive to temperature changes following tooth preparation. This sensitivity usually subsides with time and rarely persists permanently.

Initial _____ D. Some discomfort in chewing on the temporary fillings or permanently restored teeth for a few days to several weeks is possible.

Initial _____ E. There may be some restricted mouth opening for several days or weeks.

Initial _____

F. Muscle stiffness - (Trismus) Tenderness and stiffness within the chewing muscles may develop during the post-operative period, but should not alarm you. It is due to swelling in the area and is best treated with moist heat therapy.

Initial _____

G. Sore lips/cheeks - The corners of your mouth may become cracked after tooth preparation. The actual stretching of the mouth may cause soreness and during instrumentation the possibility exists of minor abrasion occuring in the corners of the lips as well as about other areas inside and outside the mouth. These abrasions will usually heal very rapidly, without complications. Whenever possible, Vitamin E cream should be applied liberally.

Initial _____

H. Incorrect bite - Following the placement of new fillings, crowns, inlays or onlays, your bite may be off, or incorrect. Please advise us of this should it occur.

Initial _____

I. There is evidence indicating local anesthesia in itself, although rare, may produce some paresthesia. This is related to the amount of covering, or myelination, about the nerves and has little to do with the mode of technique or administration. Some anesthetics, when administered, could cause an allergic response such as fainting, increased heart rate or blood pressure. They can also produce some discoloration at the injection site.

Initial _____

J. T.M.J. Pain - Some soreness may develop in your jaw joint as a result of prolonged opening or possibly as a result of adjusting the occlusion (if that was done) to a more functional position. This is usually a tempory condition which can be relieved through moist heat therapy as well as jaw-opening exercises.

Initial _____

K. Speech - Some alteration of speech may occur due to air escaping through the spaces between teeth. This is usually a temporary situation which you should have no difficulty in adjusting to.

Initial _____

L. After tooth preparation, some teeth may continue to hurt or begin to hurt after they have been comfortable for a long period of time. The tooth could become non-vital and the pulp/nerve die. If this happens, the tooth will have to be removed or root canal treatment performed, if you choose to do so.

Initial _____ M. As might occur with the placement of silver amalgam, gold or any other dental material, I understand that there are situations beyonnd the control of the dentist. A situation may occur that necessitates endodontic treatment and/or removal of an existing tooth, despite precautions taken and proper procedures utilized.

Initial _____ N. If a posterior composite resin or gold is the material I have chosen to replace my dental mercury-amalgam fillings or other non-precious materials, the advantages and disadvantages of said materials have been discussed with me and I understand my choices.

Initial _____ O. It has been explained to me, and I understand that a perfect result or results are not guaranteed or warranted, and cannot be guaranteed or warranted.

Initial _____ P. I certify that I read and understand English, and have read and fully understand this consent for the removal of mercury containing dental amalgam.

PLEASE ASK DR. _____ IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM BEFORE YOU SIGN.

Initial _____ I understand that I am personally responsible for the fees, and that the fees have been fully explained to me. As a courtesy, the basic forms and reports necessary for insurance benefits will be prepared for my use. I understand that my insurance benefits are between me and my insurance company, and that the ultimate responsibility for securing these monies is mine.

Initial _____ I understand that although no guarantees can be given, every effort has been made in the best professional judgement to give me a proper evaluation, proper diagnosis, treatment plan and prognosis.

Signature: _____
Patient

Signature: _____
Doctor

Signature: _____
Parent/Legal Guardian
(if patient is under 18)

Signature: _____
Witness
(Professional Staff Member)