Doctor's Name _____

Address _____

Phone _____

Date _____

Informed Consent for the Removal of

MERCURY CONTAINING DENTAL AMALGAM

I, _____ , hereby authorize my dentist Dr. _____ to remove dental amalgam filings and other non-precious metals from my teeth and replace them with dental materials presently considered biocompatible based on existing scientific research. These materials include; posterior composite resins, ceramic, porcelain, and gold (noble quality).

Doctor Signature _____

Any questions I had about amalgam removal were answered to my satisfaction by Dr. _____

It has been explained to me that I may have signs and symptoms of hyper-sensitivity to mercury toxicity outlined in the scientific literature. However, there is yet insufficient scientific evidence that removing amalgam fillings from my teeth will cause the cure or amelioration of **ANY** health problems or conditions. Furthermore, Dr._____ has made no representation that replacing my amalgam fillings/non-precious metals will effect or cure any specific symptoms or medical problems I may have.

Patient Name

Patient Signature