Dr. Purnima Hernandez & Dr. Selin Soyupak
23-00 Route 208, Suite 2-5,
Fair Lawn, NJ, 07410

Consent for Silver Diamine Fluoride (SDF) Treatment

Child's Name: _____ Date:_____

Parent's or Caregiver's Name: _____

I understand that my child is having the following treatment performed:

Silver diamine Fluoride treatment to stop cavities from progressing or to treat hypersensitivity.

I may refuse this treatment. Other treatment options may include: fluoride varnish, fillings, or MI Paste.

Description of procedure:

- Dry the tooth.
- Place a small amount of Silver Diamine Fluoride with micro-brush or floss.
- Seal Silver Diamine Fluoride

This will help to stop the cavity.
This may need to be done again at future appointments. I understand that treated teeth may still need other treatments, such as filings or crowns.

I will tell my dentist if I might have a silver allergy.
I will tell my dentist if I have had ulcerative gingivitis or stomatitis in the past.

Side effects include:

1. The cavity will change color to brown or black. This means the treatment is stopping the cavity. The dark stain is like a scar. Healthy tooth enamel will not stain.
2. Fillings and crowns may also change color if SDF gets on them.
3. If SDF touches the skin or gums, they may turn brown. The stain will not harm my child. The stain will not wash off. It will go away in 1-3 weeks.
4. These side effects may not include all of the possible situations reported by the manufacturer. I will let my dentist know if I notice any other side effects.

After the SDF treatment, I will avoid food and drink for 45 minutes. This will help the treatment to work better.

I AGREE THAT: I READ AND UNDERSTOOD THIS FORM. MY DENTIST EXPLAINED AND ANSWERED MY QUESTIONS ABOUT THE TREATMENT: BENEFITS, SIDE EFFECTS, AND RISKS. MY DENTIST TOLD ME ABOUT OTHER OPTIONS AND THEIR RISKS AND BENEFITS. I HAVE HAD THE CHANCE TO ASK QUESTIONS. I CONSENT TO THIS TREATMENT.

Date: _____ Signature: _____

Relationship to Patient: _____