Silver Nitrate Informed Consent

Patient Name: _________________________________________ Date: _____________

Silver Nitrate has been used in dentistry for over a hundred years. In recent years, it has been used in the Medical Management of Cavities with great success. With this as Advantage Dental Clinics’ objective and the patient’s best interests in mind, Advantage Dental Clinics would like consent to perform the following procedure.

Dry teeth
Apply 25% Silver Nitrate (FDA approved product) to appropriate teeth with visible cavities in very small amounts using a micro brush. One drop will treat 6 to 8 teeth.
Apply 5% Sodium Fluoride varnish (FDA approved product) used to seal silver nitrate into the treated tooth and kill the infection in the tooth.

Contraindications:
- Silver Nitrate Allergy (very rare)

Possible Side Effects:
- A cavity in the presence of Silver Nitrate will turn that part of the tooth dark. This is an indication that the infection in the tooth (the cavity) is dying.
- If Silver Nitrate comes in contact with skin and/or gums, temporary discoloration will occur.
- If Silver Nitrate is placed on a tooth that has a tooth colored restoration on it, discoloration may occur.
- Silver Nitrate placed on demineralized enamel (white lesions) will 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, contact your dentist or doctor.

This caries arrest treatment does not prevent the need to place a regular filling in the affected tooth in the future in order to restore function and esthetics. In many cases, if fillings are chosen after arrestment of the tooth infection, little or no anesthetic shots may be necessary in order to perform the filling.

Do not eat or drink for one hour and do not brush your teeth for 24 hours after treatment.

I hereby give permission for the patient listed above to receive Silver Nitrate and Fluoride Varnish treatments from Advantage Dental Clinics, LLC. I have read this form, understand the possible side effects of the treatment, had an opportunity to ask questions of the dentist/staff and had my questions fully answered.

______________________________  _______________________
Patient Signature or Legal Guardian  Date

______________________________  _______________________
Doctor  Date