I UNDERSTAND that dental treatment requiring SILVER AMALGAM RESTORATION procedures, which I desire to have performed, include certain risks and possible unsuccessful results or procedural failure. Even though care and diligence will be exercised in this treatment, there are no guarantees of desired or anticipated results, or of the longevity of the treatment. I AGREE to assume the risks, possible unsuccessful results or procedural failure associated with the treatment, including but not limited to the following:

_____(initials) Silver amalgam has been used for decades as a filling material for teeth. There are no proven scientific studies accepted by the American Dental Association which supports the belief by some that silver amalgam may have an effect on the general health of a person due to its mercury content. Silver amalgam continues to be endorsed by the ADA as an acceptable filling material.

_____(initials) The teeth treated may be sensitive, even painful during and after completion of treatment. If the pain becomes severe for an extended period of time, please call the doctor for an examination.

_____(initials) If anesthetic is administered, you could have numbness in the tongue, lips, teeth, jaws, and/or facial tissues. If numbness persists for a period of time longer than 24 hours, please call the doctor.

_____(initials) If the silver amalgam filling exceeds two thirds the width of the occlusal surface of the tooth, the material can be compromised, and a full coverage crown may be necessary.

_____(initials) If your tooth becomes sensitive, or painful after treatment, it may be necessary to do root canal therapy, or even extraction to resolve the problem.

_____(initials) Because silver amalgam is soft when placed, it will be necessary to not chew on the filling material for the first 24 hours.

_____(initials) It is always possible, when receiving a silver amalgam filling, for the material to cause a “tattoo” on the gum tissue where the tooth is being treated. This is caused by small pieces of the filling material becoming embedded in the gum tissue. Everything will be done to prevent this from happening.

_____(initials) It is my responsibility to contact the dentist and seek attention should any abnormal postoperative circumstances occur.

_____(initials) I will diligently follow any preoperative and postoperative instructions given me.

Remainder of This Page Left Blank Intentionally
Signature Page to Follow

VOLUNTARY INFORMED CONSENT TO TREATMENT

As indicated by my initials above and my signature below, the doctor and dental team have given me the opportunity to read this document in its entirety and have allowed me to ask any and all questions pertaining to the procedure(s) above, their nature and purpose. They have also explained to me alternative forms of treatment and the risks of nontreatment. They have answered all my questions and concerns to my satisfaction with language I could understand. I voluntarily assume any and all possible risk, including risk of substantial harm, if any, which may be associated with any phase of this, or any unforeseen additional, dental treatment in hopes of obtaining the desired results for me, or for my minor child or ward. I also voluntarily assume the risk that the desired result may not be achieved. I have also been given the option to seek treatment from a specialist. No guarantees or warrantees have been made to me concerning the results. Moreover, the fee(s) associated with these services have been explained to me, and I accept the financial responsibilities.

By signing this form, I am willingly, under no duress, giving my consent to allow and authorize the doctor, dental team members, and their associates, to render any treatment they believe necessary, appropriate, and/or beneficial to me, or my minor child or ward, including the administration and prescribing of any/all anesthetics and/or medications.

Patient's Name	Signature of Patient, Legal Guardian, or Authorized Representative	Date
Tooth Number(s)	Witness to Signature	Date
Healthcare Provider's Name	Signature of Healthcare Provider	Date

Dr. Rod Maxfield
31 W 100 S, STE A
Pleasant Grove, UT 84062
www.RodMaxfieldDDS.com
801-785-2631