I UNDERSTAND that dental treatment requiring SEALANT procedures, which I desire to have performed, may present certain risks and possible unsuccessful results, with even the possibility of procedural failure in an attempt to achieve the results which may be desired or expected. Even though care and diligence will be exercised in this treatment, there are no guarantees of anticipated or desired results, or of the longevity of the treatment. I agree to assume those risks, possible unsuccessful results and/or failure associated with, including, but not limited to the following:

_____(initials) The teeth are prepared through the use of an enamel etching technique or with a very small bur tool on a dental handpiece that opens up the deep grooves on the surface of the tooth. Etching is typically done with an acid etching solution, or with particles emitted through a micro air hose that "roughs up" the groves in the tooth for bonding of the sealant material. You may experience discomfort from the dust of micro-abrasion, or from the bur tool that is attached to the dental handpiece. Keeping as still as possible is critical to the success of a sealant.

_____(initials) Dental sealants do not last forever. They can lose their bond, or they can break due to the forces of chewing. They can dislodge due to the types of food we eat. Poor oral hygiene can also cause sealant failure due to decay around the sealant.

_____(initials) Sealants are only designed to protect the chewing surface of the tooth. Thorough brushing and flossing is necessary to prevent decay on other tooth surfaces.

_____(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 warranties 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

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