

Informed Consent for Silver Diamine Fluoride (SDF)

Facts for consideration:

- Silver Diamine Fluoride (SDF) is an antibiotic liquid. We use SDF on cavities to help stop tooth decay. We also use it to treat tooth sensitivity. SDF application every 6-12 months is necessary.
- The procedure: 1) Dry the affected area, 2) Place a small amount of SDF on the affected area, 3) Allow SDF to dry for one minute, 4) Rinse or dry with cotton.
- **Treatment with SDF does not eliminate the need for dental fillings or crowns to repair function or esthetics. Additional procedures will incur a separate fee.**
- I should not be treated with SDF if: 1) I am **allergic to silver** 2) there are painful sores or raw areas on my gums (i.e., ulcerative gingivitis) or anywhere in my mouth (i.e., stomatitis).

Benefits of receiving SDF:

- SDF can help stop tooth decay.
- SDF can help relieve sensitivity.

Risks related to SDF include, but are not limited to:

- **The affected area will stain black permanently.** Healthy tooth structure will not stain. Stained tooth structure can be replaced with a filling or a crown.
- Tooth-colored fillings and crowns may also discolor if SDF is applied to them. Normally this color change is temporary and can be polished off.
- If accidentally applied to the skin or gums, a brown or white stain may appear that causes no harm, cannot be washed off, and will disappear in 1-3 weeks.
- You may notice a metallic taste. This will go away rapidly.
- If tooth decay is not arrested, the decay will progress. In that case the tooth will require further treatment, such as repeat SDF, a filling or crown, root canal treatment, or extraction.
- These side effects may not include all of the possible situations reported by the manufacturer. If you notice other effects, please contact your dental provider.
- Every reasonable effort will be made to ensure the success of SDF treatment. There is a risk that the procedure will not stop the decay and no guarantee of success is granted or implied.



Alternatives to SDF, not limited to the following:

- No treatment, which may lead to continued deterioration of tooth structures and cosmetic appearance. Symptoms may increase in severity.
- Depending on the location and extent of the tooth decay, other treatment may include placement of fluoride varnish, a filling or crown, extraction, or referral for advanced treatment modalities.

Please sign for permission on front of the form. If questions, call CDH Oral Health at 208-327-8612



NO-COST CAVITY PREVENTION CLINIC

Please complete and return to your teacher immediately!

Student Demographics:

First Name: _____ Last Name: _____ Teacher's Name: _____

Date of Birth: _____ Age: _____ Grade: _____ School: _____

Gender: Male ☐ Female ☐ Hispanic/Latino: Yes ☐ No ☐

Race: (circle one) White, Black, Native American, Asian, Pacific Islander, Other.

Is your child taking any medications or does your child have any allergies including foods, medication, etc.?

Yes ☐ No ☐ If yes, please list: _____

Services:

Please mark the services you would like by checking Yes or No for each item below. If you select no to ALL services below, please skip to the signature line at the bottom of the page:

Yes ☐ No ☐ I want my child to get **sealants**

Yes ☐ No ☐ I want my child to get **fluoride** varnish

Yes ☐ No ☐ If time permits, I would like my child to have a dental **cleaning/prophy**

Yes ☐ No ☐ **Please see reverse side of form before selecting.** I consent to my child receiving **Silver Diamine**

Fluoride (SDF) to help stop cavities that have started. I certify that I have read and fully understand the document on the reverse page, and all my questions were answered.

Insurance: (Must be Complete to Receive Services)

Is your child enrolled in Idaho Smiles or Medicaid? Yes ☐ No ☐ Medicaid #: _____

Is your child covered by private dental insurance? Yes ☐ No ☐

Name of Dental Insurance Company: _____ Insured's Employer: _____

Name of Insured (parent who has the policy): _____ Male ☐ Female ☐

Insurance Address: _____

Address of Insured: _____

Phone Number of Insured: _____ Insured's Date of Birth: _____

Policyholder/Subscriber # (ID or SS#): _____ Group Number: _____

Permission:

☐ I give permission for my child to participate in the Sealant Clinic and receive preventive dental services that may include visual dental screening/assessment, sealants, fluoride and re-evaluation and repair (if necessary) of sealants at a later date. I also acknowledge that I have had the opportunity to review Central District Health's (CDH) Notice of Privacy Practices located at: <https://cdh.idaho.gov/health/clinics/#hipaa> I authorize the release of information on my child's dental visit to CDH, my child's elementary school, Medicaid (Idaho Smiles) or other insurance companies as applicable. I authorize and direct payment of the dental benefits otherwise payable to me, directly to CDH. I am a custodial parent or legal guardian of the minor child named above. I authorize and consent to this child receiving the dental treatment described above.

☐ I decline participation in the Sealant Clinic

CDH provides WIC services to those who qualify.

Please scan the QR code for more information and to apply.



Parent or Guardian's Signature: _____ Date: _____

Home Phone: _____ Cell #: _____ Email: _____