DELTA DENTAL

SILVER DIAMINE FLUORIDE INFORMED CONSENT

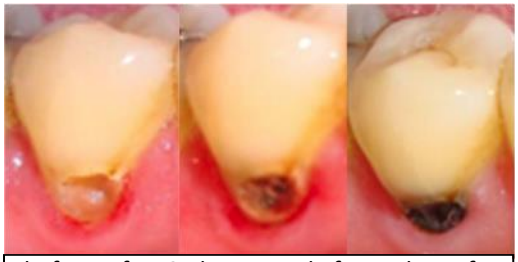
Silver Diamine Fluoride (SDF) is a liquid medication that is applied to active tooth decay to kill bacteria and stop the cavity from growing. While the use of SDF has been FDA approved to treat tooth sensitivity, we are using SDF to help stop tooth decay.

Benefits of receiving SDF:

- SDF can help stop tooth decay.
- SDF can postpone the need for traditional dental treatment (fillings, crowns, etc.) and delay/possibly eliminate the need for sedation/general anesthesia to complete dental treatment.

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

- Patients should not be treated with SDF if:
  - **He/she has an allergy to silver**.
  - There are painful sores or raw areas on the gums or anywhere in the mouth.
- **The decayed area of the tooth will be stained black permanently.** Healthy tooth structure will not stain.
- Tooth colored fillings and crowns may discolor if SDF is applied to them.
- If SDF contacts the gums or skin, a brown or white stain may appear. This color change is harmless, but cannot be washed off. The discoloration will go away in 1-3 weeks.



before, after 24 hours, and after 7 days of SDF treatment (UCSF Dental Center)

- If tooth decay is not arrested, the decay will progress. In that case the tooth will require further treatment, such repeat SDF, a filling or crown, root canal treatment, or extraction.

Alternatives to SDF include, but are not limited to:

- No treatment. No treatment will allow untreated decay to continue further damaging tooth structure, possibly leading to pain, infection, or tooth loss.
- Fillings, crowns, extractions or referral for advanced care which may include general anesthesia.

While SDF can stop tooth decay, it will not restore the tooth structure that has already been effected. You may still require restoration of the teeth (fillings, crowns, etc.).

I certify that I have read and fully understand this document. All of my questions have been answered.

Patient Name: _____ Date of Birth: _____

Parent/Legal Guardian Signature: _____Date: _____

Parent/Legal Guardian Name (Please Print):_____

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Delta Dental Mobile Program
Patient Information Form

Please fill out this form completely. If you have questions, please ask a Delta Dental staff member. Thank You!

Patient's Legal Name _____ Birth Date (mm/dd/yyyy) _____

School Attending _____ Grade _____ Age _____ Sex ☐ M ☐ F

Ethnicity: ☐ *White* ☐ *Black or African American* ☐ *Asian* ☐ *American Indian* ☐ *Hispanic/Latino* ☐ *Other*

Home Address _____
Mailing Address City State Zip

Phone Numbers: Home (_____) _____ Work (_____) _____

Cell (_____) _____

Parent/Guardian Name _____ Relation to patient _____

Emergency Contact: Person to contact in case of an emergency

Name _____ Relation to patient _____ Phone (____) _____

Income: Which of these best represents your annual household income?

☐ *Less than $10,000* ☐ *$10,000-20,000* ☐ *$20,000-30,000* ☐ *More than $30,000*

Household Size: How many children age 21 or younger live in your household? _____

Dental History (Note: Dental visits should start at first tooth.)	Yes	No	
Is this the patient's first dental visit? Past or current dentist name_____	☐	☐	If no, how long has it been? (√) ☐ less than 2 years ☐ more than 2 years
Has the patient visited the ER/hospital for dental pain in the last year?	☐	☐	If "yes", how many times?
Has dental pain caused you or your child to miss school and/or work in the last year?	☐	☐	If "yes", ☐ school ☐ work ☐ both How many times?

Medical History	Yes	No	Please Explain "yes" Answers
Patient's current physician _____ Date of last medical exam (mm/yy) _____			
Does the patient have a current medical condition?	☐	☐	
Is the patient taking any medications?	☐	☐	
Has the patient ever been hospitalized or had surgery?	☐	☐	
Does the patient have any allergies?	☐	☐	
Does the patient have any special needs that would require special arrangements for dental care? i.e. autism	☐	☐	
Is patient pregnant?	☐	☐	

Has the patient had a history of or had difficulty with the following? Check any that apply (√)

☐ AIDS / HIV	☐ Cerebral Palsy	☐ Fainting	☐ Liver disease
☐ Anemia	☐ Diabetes	☐ Heart problems	☐ Mono
☐ Asthma	☐ Epilepsy/ seizures	☐ Hepatitis	☐ Rheumatic fever
☐ Birth defects	☐ Excessive bleeding	☐ Kidney disease	☐ Tuberculosis
☐ Cancer	☐ Other _____		

Please explain your answers: _____

Reason for Visit: Check any that apply (√)

☐ First examination ☐ Couldn't afford dental care ☐ Couldn't get appointment anywhere else

☐ Toothache/mouth pain/face swelling ☐ Other (specify)_____

Patient Behavior	Yes	No	
Does the patient brush daily?	☐	☐	
Does the patient drink soda pop or other sugar sweetened drinks daily (Kool-aid, fruit drink, Gatorade, sport drinks)?	☐	☐	
Is the patient using tobacco products (cigarettes, chewing tobacco, smokeless tobacco)?	☐	☐	
Does anyone in the household use tobacco products (cigarettes, chewing tobacco, smokeless tobacco)?	☐	☐	

Insurance: Please check any that apply. If Medicaid or private dental insurance, please indicate Medicaid number or policy number in the space provided.

MUST PROVIDE A COPY OF YOUR DENTAL INSURANCE CARD IF APPLICABLE.

☐ Medicaid/ SCHIP ☐ Private DENTAL Insurance (please provide copy of card) ☐ None

Medicaid Number/ Policy Number _____

Dental Ins. Name: _____ policy #_____ group # _____

Dental Ins. Address: _____ Ins. Phone # _____

Employer Name: _____

Treatment Consent and Agreement

I, _____, as a legally responsible guardian of _____
(print parent/legal guardian name) (print child's name)
give my consent for the dental services I have authorized below. I understand there may be risks involved with dental treatment. Please note that preventive dental hygiene services alone, provided outside of a regular dental office, should not replace regular dental exams by a dentist. Each item needs to be answered in order to receive dental care.

Yes	No	
☐	☐	Preventive Services: screening by a hygienist, teeth cleaning, oral hygiene instruction, sealants, fluoride treatment.
☐	☐	Dentist Exam (including dental x-rays)
☐	☐	Restorative Services: fillings, stainless steel crowns, pulpotomy. Local anesthetic may be used for these procedures.
☐	☐	Extractions: removal of primary (baby) or permanent teeth that cannot be restored through other treatments. Local anesthetic may be used for these procedures.
☐	☐	The use of nitrous oxide (laughing gas) may be used as deemed necessary.
☐	☐	I have been offered and/or read a copy of the Delta Dental's HIPAA Notice of Privacy Practices.

➡ Parent/Legal Guardian signature _____ Date _____