STATEMENT OF CONSENT FOR AMALGAM REPLACEMENT PROCEDURES

1. I hereby authorize Dr. _____ and/or other dentists or assistants as may be selected by him/her to treat my condition(s). The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure as follows:_____
_____
_____

2. I have been informed of my current dental diagnosis and of possible alternative methods of treatment (if any).
3. I further understand that this is an elective procedure and that other forms of treatment or no treatment at all are additional choices that I have, and I have discussed the known risks of these other forms of treatment with my dentist(s).
4. I understand that replacement of dental amalgam in a non-allergic patient does not indicate that the doctor is of the opinion that amalgam is a health hazard.
5. The doctor has explained to me that there are certain inherent and potential risks in ANY treatment plan or procedure. We do not expect these to occur, but there is that possibility. In this specific instance such risks include, but are not limited to, the following:
   A. Nerve inflammation leading to hot and cold sensitivity.
   B. The need for endodontic therapy (root canal treatment).
   C. Cracked cusps.
   D. A shorter length of serviceability of the restoration with the need for more frequent replacement.
   E. In cases where the previous restorations (fillings) are very large, the use of cast or full coverage crowns, or bonded porcelain are often recommended.
6. It has been explained to me that, during the course of the procedure(s), unforeseen conditions may be revealed that may necessitate an extension of the original procedure(s) or different procedure(s) than those set forth in paragraph #1 above. I, therefore, authorize and request that the persons described in paragraph #1 above perform such procedures as are medically necessary and desirable in the exercise of his or her professional judgment. The authority granted under this paragraph #6 shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.
7. I consent to the administration of anesthesia, including local, intravenous and/or general anesthesia in connection with the procedure(s) referred to above, by any of the persons described in paragraph #1, and to the use of such anesthetics as may be advisable with the exception of: _____ _____ to which I said I was allergic. I recognize that there are always risks to life and health associated with anesthesia and such risks have been fully explained to me.
8. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus I have been advised not to operate any vehicle, automobile, or hazardous devices, or work, while taking such medications and/or drugs; or until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device until I have recovered from the effects of the anesthetic medication and drugs that I may have been given in the office for my care.

9. It has been explained to me, and I understand, that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.
10. I agree to cooperate completely with the recommendations of the doctor while I am under his/her care, realizing any lack of same could result in a less than optimum result and that failure to follow the doctor's suggestions and directions could be even life threatening.
11. I have been given ample opportunity to ask questions and any questions I have asked have been answered in a satisfying manner.

12. I certify that I read and write English and fully understand this consent. **PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM BEFORE SIGNING IT.**

_____	_____
Signature of patient	Date
_____	_____
Witness	Date
_____	_____
Dentist	Date